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DETERMINING THE DEGREES OF NEEDED SUPPORT FOR FIRST TIME PARENTS
in the
IMMEDIATE AND EARLY POST PARTUM PERIOD

A DISSERTATION

submitted by

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Determining Degrees of Needed Support in the Immediate and Early Post Partum Period

This study developed an assessment protocol which estimated the degree and nature of support necessary to facilitate a smooth transition into the parenting role for first-time parents, as they incorporated the baby into their family unit. This study, supported by research, is based on the premise that every first time parent requires some degree of physical and emotional support in the immediate and early postpartum period. It is a study that stresses the benefits of universal post partum support.

Fifteen couples volunteered to participate. These couples met the criteria of being first time parents, anticipating an uncomplicated delivery, and had maintained a dyadic relationship for a minimum of one year. The first interview was scheduled in the third trimester. The participants were either recruited from pre-natal exercise programs, or responded to posted flyers, word-of-mouth and snowball effect. The individuals in each dyad agreed to be interviewed separately. Elements included in the assessment protocol were developed from an in-depth review of the literature and gleaned from personal clinical experiences. An open-ended qualitative interview was designed to capture the assessment elements. Categories in each element represented predictors for needed support. At the end of the interview each individual was asked to choose from a list of support options which he/she believed would prove to be helpful in the immediate post partum period. Support needs were categorized according to the number of predictors that were flagged. The results ranged from minimum, moderate or maximum support required.

Couples were interviewed one month after the birth. Results from the protocol were compared with what support they truly received and/or needed. The protocol accurately assessed the degree of necessary support. All couples agreed they did not know what they would actually need. There was discrepancy between perceived and actual need. All agreed that the first two weeks post partum were the most important time to have both formal and informal support. Three elements that predicted an easier transition were ego development and how individuals functioned as a couple.

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I would like to thank the men and women in this study who unselfishly opened their homes and their hearts describing their experiences.

I extend a warm welcome to the babies and wish success to their parents who ran ahead to learn the way for the many future parents who will travel the same path.

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Preface

I have been practicing clinical nursing for over thirty years, with a brief hiatus of about three and a half years, when I was at home working full time as a mother. Over the last twenty-five years of my nursing career I have focused on health related issues of children, parents and families.

It was during my clinical experience as a psychiatric staff nurse and later, as the program manager of an in-patient unit for emotionally disturbed children, that I became keenly aware of the commitment and hard work the art of parenting entailed. As I reflected on my own experiences as a parent, I vividly recalled the tensions, the anxieties, the pleasures, joy, and pride as well as the feelings of inadequacy and guilt.

I listened to the parents of the hospitalized children as they described their attempts to parent their child. I listened to their pain. They described their efforts to seek help from the "experts". They often were blamed for their child's difficulties. They readily admitted to feelings of shame and inadequacy for having "failed" at a task that society implies is instinctive.

What was impressive to me were families who perceived the assistance of the staff to be helpful, rather than judgmental and critical, tended to be more receptive to developing effective parenting skills. The more the families felt nurtured by the staff, the more willing they were to try new parenting styles and seemed more emotionally available for their child.

As I reflected on these children and families, the more I came to appreciate the enormous responsibility placed on parenting. With this realization, I began to think about the burden placed on these particular parents. I became more aware of the high expectations we, as a society, place on new parents who receive little or no preparation or support for the task at hand. A combination of my clinical nursing experiences and the research

literature have supported and confirmed this belief.

As a result of my earlier experiences and impressions, I conceptualized the development of an assessment process that would occur during a couple's prenatal phase of their parenting experience. This planned assessment would be designed to determine the prospective parent's degree of *risk* for parenting. Through the process of study, research, observations and interviews with new parents, I came to realize that the focus should not be *risk*, but rather, *the need for support*. First-time parents, in particular, need support, reassurance, validation and teaching.

Parenting is not a job; nor is it a skill that can be learned in much the same way one learns to cook, or use a computer, or drive a car. *It is a relationship*, one that cannot simply be taught or re-taught if it has not been 'learned' well initially (Musick, 1990, p.27).

The ability to parent, i.e. nurture, support, guide, comfort and foster emotional, social and cognitive growth in one's offspring throughout his/her developing years, is far from an instinctive process. It is a process embedded in the development of a relationship with one's own parents within the context of one's own upbringing, which is influenced by parental and cultural practices. Further, it appears that one's ability to parent can be influenced and enhanced by one's exposure to infants and children, modeling from one's parents and close friends and various sources of support. Joan Hammerman Robbins states,

Throughout our history we have not been able to separate child bearing from child rearing. This has limited our ability to notice that the care of the infant is its initiation rite into humanness and therefore any human can do it (Robbins, 1980, p. 32).

I propose, however, that the quality of care that a parent provides to the infant and developing child is directly related to the caretaker's experience of

being nurtured and cared for, as evidenced by the parents of the hospitalized emotionally disturbed children who responded to the staff's nurturing. Along with the experiences of being nurtured, it is the opportunity for the child throughout one's developing years to practice those nurturing skills.

John Bowlby suggests that parenting behavior is pre-programmed to some degree and therefore ready to develop along certain lines when conditions elicit it. He warns that this does not imply that all parenting behavior patterns manifest themselves in every detail at first.

All the detail is learned--some of it during interaction with babies and children, much of it through observation of how parents behave, starting during the prospective parents' own childhood and the way his parents interacted with him and his siblings (Bowlby, 1988, p. 5).

Bowlby believes that parenting behaviors have a strong biological root, but the detailed form of that behavior is influenced by one's experiences. He believes that these influential experiences have progressed along life's continuum and includes one's experiences with each individual child (Bowlby, 1988).

Dorothy Dinnerstein adds another dimension. She argues that the initial post partum ties of mother to newborn originate in the central nervous system. She suggests that the mother is passionately connected to the infant through both bodily and intellectual responses. These responses are based on a mother's memories of the baby in utero. These memories remain with her throughout the child's growth and development and even into her child's advance in years, thereby perpetuating the mother/child bond. She, however, argues that this same bond has been the yoke for women who are expected to carry the entire "burden" of parental function, expecting that because of this bond she should have the knowledge and answers to parent the child beyond infancy (Dinnerstein, 1976). Dinnerstein reminds us that humans, both male

and female, with intellect, are radically different from animals.

It is true for men as for women that the question of what constitutes physiologically determined parental behavior must be answered in terms that embrace our most distinctive physiological properties: the organs that govern our actions as parents include organs of intellect (Dinnerstein, 1976, p. 80).

Kitzinger speaks of the myth of maternity. She recounts a myth which asserts that mothers have loving, tender feelings about their babies and have become different from their former selves as a direct consequence of the biological act of having given birth. It is believed that these changed women are now selfless, giving, and experience supreme satisfaction in sacrificing themselves, especially for their offspring (Kitzinger, 1978). She includes in this myth an image of the Virgin Mother who is untouched by anxiety or passion, a representation of feminine purity, totally devoted to her child. Kitzinger suggests that this myth has evolved as a result of society divorcing sexuality from the emotions involved in mothering. She warns that this separation has created a romanticized model of motherhood that women cannot possibly attain. She suggests that the creation of this model has caused women to experience a sense of hopelessness and failure in their attempts to act a part they neither feel suited for or will ultimately fall too short in attaining (Kitzinger, 1978).

Madeline Drexler, in her article, "Mother, Please," states,

When women see through the myths of motherhood, especially the notion that all mothers are natural nurturers they see their failures often stem not from personal deficits but from the way society is structured (Drexler, 1991).

Kitzinger stresses that one's ability to mother is learned in most cultures from infancy, both by being nurtured and by being exposed to nurturing behaviors through modeling. However, in our post-industrial society of high technology and isolated nuclear families, she recognizes that these important skills have often been neglected (Kitzinger, 1978).

Kitzinger suggests that a "style of mothering" is an expression of culture and is directly related to social classes. Her view is that a mothering style embodies a value system relating attitudes about women, children and motherhood (Kitzinger, 1978). She states,

We cannot alter styles of mothering without ultimately also changing larger society and re-examining what it is to be male and female, what it is to be a child, the role of parents and the significance of the family in that culture (Kitzinger, 1978, p. 9).

Author and psychologist, Jack Heinowitz agrees that parenting is not a sex-linked trait. Drawing from his doctoral research, he has identified that motivated fathers are as sensitive and competent as mothers in their ability to respond to infant cues and provide nurturing care. Heinowitz states,

Parenting is, in final analysis, a fundamental way of being with another person - a way of conveying affection and understanding, of transmitting beliefs and values, and of relating beyond ourselves through acceptance, committed involvement, and love (Heinowitz, 1995, p.23).

In looking at his analysis there is a striking resemblance to the behaviors one employs when developing and fostering a relationship. His analysis is congruent with Musick who defines parenting as a relationship rather than a job or skill.

In order to pursue the idea that females are not natural nurturers simply because they biologically delivered a baby I conducted a small research project (Fraktman, 1991). I purposefully chose a population who society believes are natural nurturers because they were mature, educated and financially secure. I interviewed a small sample of white, educated, professional women, aged thirty to thirty five years, who had maintained a relationship with their partner for two to five years. These first-time mothers conveyed a consistent theme of being unprepared and often ill equipped to meet the demands of caring for their new

infants, replicating the themes identified in the literature cited above.

When I asked, "How does it feel to be a new mom?"

T. answered,

Well, it's a lot of work! I guess you figure it's just like playing dolls when you were a little girl. It's like worrying when they get sick and just not knowing the unknown (Fraktman, 1991).

E. responded,

Traumatic, overwhelmed! I felt I had gotten all this preparation about the pregnancy and the birth and labor, but felt that when I came home I didn't know what to do with this baby (Fraktman, 1991).

All the new mothers agreed that they experienced some instinctive or maternal feelings. They qualified these feelings as being more related to infant survival such as feeding, comforting, maintaining cleanliness, and safety. These "instinctive" elements, however, did not appear sufficient enough to sustain the mothers who spoke of their frustration, inadequacy and failure of becoming a "good mother" as their efforts to comfort and quiet a distraught and crying infant were unsuccessful. They elicited support from their partners who in turn looked to them as the "experts" in these matters. One mother asked, *How do you know what you don't know? How do you ask questions when you don't know the questions to ask?*

Pregnancy and childbirth in industrial societies have become medical events. Women have their babies in hospitals and are primarily serviced by physicians. Women who have "uncomplicated" normal deliveries in the 1990's are often discharged from the hospital within twenty-four hours post partum. Physically exhausted and emotionally drained, the couple return to their home with their new infant and muddle through the fog of beginning parenthood (Eagan, 1985). The practice of families, neighbors or close friends providing emotional and physical support to a woman who has just given birth is becoming an uncommon and an almost unexpected event. The phenomenon of

an isolated nuclear family has become more commonplace (Rothman, 1991).

An ongoing controversy between some health care professionals and the insurance agencies, especially Health Maintenance Organizations (HMO), has become so heated that the issue has become politicized. Lois Pines, Massachusetts State Senator, drafted a bill that requires insurance companies to cover a woman's hospital stay for a minimum of 48 hours for all vaginal deliveries and a minimum of 96 hours for Cesarean deliveries. In addition she has included some form of post delivery care services (June 29, 1995 The News Tribune, p.4). Some groups representing women, doctors and health care professionals argue that the issue is not necessarily extending hospital stays. They argue that the issue is providing home visits and follow-up care that would be paid by the health plans (1995, July 16 Boston Globe, p.16). One physician argued that extending the hospital stay does not necessarily guarantee problems won't arise after discharge. He argued that placing a greater emphasis on teaching in the pre-natal phase combined with phone calls, visiting nurses and a follow-up check-up three days post partum may be a more effective plan of care (June 29, 1995 The News Tribune, p. 4). Pines stressed that the point of the bill is to expand women's options following the birth of her baby (June 29, 1995 The News Tribune). This political argument has expanded to other states and has reached the desk of the President, who, in 1996, has signed a federal bill mandating minimum hospital stays similar to the Pines' legislation.

It is interesting to note that prior to the approval of Massachusetts bill, the Bureau of Family and Community Health and the Bureau of Health Quality Management jointly received twenty-seven letters addressing Section 105 CMR 130.665, Home Visits. These letters specifically addressed the need and benefit of expanding home visit professionals to include doulas, lactation consultants,

and/or maternal health providers in order to provide comprehensive, individualized, nurturing home care during the post partum period. In spite of the fact that this item received the highest number of letters, it was not included in the final draft of the bill. This omission continues to demonstrate that the welfare of women and infants are not a priority. It also illustrates the lack of understanding of post partum recovery. Further, it perpetuates the myth that the transition to the parenting role is an instinct rather than a difficult and often stressful process.

It is well documented that the joyous and even exhilarating event of becoming first-time parents is equally fraught with high levels of stress. Those stresses include both physiological stress (Blackburn, 1992; and Rose, 1989) and psychosocial stress (Gladieux, 1987; Belsky, 1984; and Belsky, 1994). Parents describe a sense of disequilibrium (Plutzik: 1983) heightened anxiety (Belsky, 1984) and, in extreme cases, clinical depression has been diagnosed in the early post partum phase of parenting (Mammen, 1993; and Stern, 1983).

Though the birth of a new baby has been identified as a time of high stress for new parents, it is also a time identified as a critical period for learning. However, resources seem unavailable or inaccessible. Many parents receive little or no information during the post partum period to assist them in the psychological, physical or emotional transitions that accompany bringing baby home (Ewy, 1988). The notion of ameliorating some of these stresses with provision of support services in the immediate post partum phase has continued to focus primarily on a high risk population, which includes single parents, adolescent parents, women with compromised pregnancies, premature deliveries, multiple births, some groups of immigrant parents and women of color. Often the support services provided may include weekly home visitation by a registered nurse, home health aide services, and early intervention

services for premature infants or those diagnosed with special needs.

What has become glaringly obvious throughout this research review is the lack of support services available to intact couples, who may, incidentally, be more educated, or more financially solvent, though not immune to the stresses of the transition. This lack of social support appears to be based on several assumptions.

Assumption I supports the myth that biologically delivering a baby initiates an automatic process in the mother who will instinctively know how to nurture and care for her baby. Breast feeding one's baby is included as part of this instinctive process. Research, on the other hand, continues to dispel this myth, suggesting that parenting is a relationship developed over time and has a direct correlation to how one was parented (Braverman, 1989; Berry, 1993).

Assumption II supports the notion that more educated and financially secure parents are more able to access resources to assist them in their new role. Even though there is some validity to this assumption, there are those educated, financially able new parents who experience high levels of stress and anxiety. They often do not seek support services because they believe the myth that they should know what to do. In addition they do not seek support services because they mistake feelings of vulnerability with signs of weakness, which doesn't fit with society's image of what being a mother is all about (Placksin, 1994). The result is a new parent who is often immobilized and isolated by shame and guilt (Rose, 1989; Sears, 1995).

Assumption III suggests that the older, more mature, and professionally successful parent will smoothly transition into the parenting role. The successful professional confronted with a crying infant she/he fails to calm can be devastated which results in the same shameful and guilty immobilization (Gladieux, 1987; Belsky, 1994).

Assumption IV professes that mothers are the designated caretakers of the infant (Berry, 1993). This is their "calling" and life's work. This assumption, however, is contradicted in our society by the lack of value placed on this work, which can often result in isolation, low self-esteem, and financial dependence for the woman, as well as creating possible tension in the dyadic relationship. In addition it appears that this assumption applies only to white women since many black women have historically experienced a double work day, one of maintaining a family and one working out of the home (Dill, 1994).

In a society in which the dominant ideology has held that the women's place is in the home, the African-American woman's status as a worker becomes a point of departure (Mullings, 1994, p.266).

Racial oppression has denied black families sufficient resources to support private, nuclear family households (Collins, 1991). Child care was a collective responsibility which fostered cooperative, age-stratified, woman-centered "mothering" networks (Collins, 1991). These intergenerational networks were established because African-American communities recognized that vesting one person with full responsibility for mothering was impractical and potentially impossible.

This assumption is also challenged within some European communities (Denmark, France, Italy, Finland and England), where support programs and child care programs have been developed to meet the needs of families and, in particular, the needs of parents in the work force (Kamerman, 1994).

Emotional support and frequent medical visits are emphasized in the prenatal phase (Kendall-Tackett, 1994). Emotional support and high technology are readily available during the prenatal and perinatal phase. Once the baby is born, emotional support provided by health care providers evaporates. This perpetuates the myth that the transition to parenthood is instinctive and

becomes operationalized at the time of the baby's birth. Medical services become fragmented. The newborn receives medical care from the pediatrician, whom the parents may have met once prior to delivery or not until after the delivery. A woman, over the forty weeks of gestation, has had an opportunity to establish a relationship with the obstetrical health team. In contrast, she has had little or no opportunity to develop a relationship with her baby's pediatrician. She is, therefore, reluctant to seek information from the pediatrician who she hardly knows. Additionally, she is embarrassed to ask questions she thinks she is supposed to know the answers to. The new mother continues to receive 'cursory' medical supervision by her obstetrician/ gynecologist. In six weeks, however, she returns to her primary care physician (PCP) or general practitioner.

The first-time parents who receive formal support in the immediate and early post partum phase are those women who have given birth to low birth weight babies, such as premature infants or multiple births. The other group of first-time parents most likely to be referred for formal support have been identified as either '*high risk*' or '*knowledge deficit*' with the potential for abuse and neglect, otherwise known as *failed* parenting. Often women of color, minorities, teens, single parents and some immigrant families fall into this category. These underlying assumptions sparked the idea of developing an assessment process which would include a support protocol

This assessment process was formulated to include a support protocol that would determine the *degree of support* required by new parents in the immediate and early post partum phase of their parenting experience. An assessment protocol is designed with the idea of implementing universal post partum support along a continuum of need.

The concept of universal support implies no stigma, no emergency, and

no abnormality (Wharf, 1988). The client oriented categorical approach to program eligibility and delivery, referred to as the residual social policy, is typical of human service programs in the United States. This approach attaches a stigma to service. Eligible consumers quickly come to realize that eligibility implies insufficiency. Those with self respect attempt to avoid the service and those who enlist it are more often put down, rather than uplifted. Responsibility for identification of needs is in the hands of the provider, rather than the consumer. This fosters a passive recipient role, which defeats the goal to foster independent, self-supporting individuals and families (Cochran, 1985). Universal post partum support acknowledges that transitioning into the parenting role is stress provoking and that parenting is hard work. Both the stress and the difficulty warrant some degree of social support. Determining the degree of required support acknowledges the strengths of the recipients and empowers them to explore those support networks that may be available and accessible to them.

The elements that I plan to include in my assessment are based on my own ideas supported by research. They are gleaned from observations and interviews with parents of emotionally disturbed children, with parents and prospective parents who participated in my small research projects, and from conversations with parents whom I have serviced as a visiting nurse.

Before undertaking this project it was necessary to determine if any similar assessments had been developed. It was equally necessary to determine if a post partum support protocol had been developed. My investigation revealed that neither an assessment or support protocol of this nature has been developed or implemented.

Definition of Terms

Social Support

Resources provided by individuals who provide emotional benefits, which might include a sense of meaning, belonging or acceptance. In addition it can include tangible support, such as transportation or child care assistance or instrumental support (Koeske, 1990, p. 442). Social support can be provided by family, friends, neighbors, trained volunteers, para-professionals or professionals.

Formal or Instrumental Support

Refers to advice, information, assistance with family or work responsibilities and financial aid. Formal support is commonly provided by professionals, para-professionals or trained volunteers who represent agencies or institutions (Thoits, 1982, p.148).

Informal Support

Refers to affection, understanding, acceptance and esteem from others. This support is commonly provided by family, neighbors and friends (Thoits, 1982, p.148).

Social Support Network

A network of friends, relatives or colleagues who serve as an extension of the individual's resources who provide knowledge, skill and emotional reserves (Vaux, 1988) Networks provide shared norms, values and ideologies (Oakley).

Social Support System

A system that consists of a subset of persons in the individual's total network upon whom one relies for socioeconomic support, formal support or both (Thoits, 1982, p.148).

Doula

Doula is a Greek word referring to an experienced woman who helps other women. The word has now come to mean a woman experienced in childbirth who provides continuous physical, emotional, and informational support to the woman before, during and after childbirth (Klaus, 1993).

Intact Couple

Based on the research of Lawrence Kurdek and Patrick Schmitt (1986), who adapted their work from a six stage model of relationship development designed by McWhirter and Mattison, intact couples refers to individuals who have maintained a dyadic relationship for a period of at least one year, ideally two or three years, to include married heterosexual partners, or cohabitating heterosexual and lesbian partners.

Introduction

Since the turn of the twentieth century, pregnancy has evolved from an event often viewed as a natural process to an event that society is led to believe, possesses inherent risks, requiring frequent prenatal visits. Giving birth commonly occurred in the home and was primarily attended by women. At the turn of the century, women began to deliver their babies in the hospital and were attended by physicians. Throughout the twentieth century until present day, giving birth has increasingly become viewed as a potentially dangerous event necessitating physician attended births in the hospital and the implementation of sophisticated technology. However, the practice of midwifery has slowly again become an accepted alternative to physician managed care. The use of birthing centers, as an alternative to a hospital delivery, have slowly gained in popularity. In contrast to the close attentive care a woman receives throughout the stages of her pregnancy, the provision of social support for new parents in the immediate post partum period is strikingly absent.

The concept of social support with its benefits in assisting couples as they transition into the parenting role is well documented. However, the increasing dependency on sophisticated technology, the commonly accepted isolation of nuclear families, compounded by accessible, modern travel which has separated extended families, have all contributed to the erosion of social support.

The purpose of this dissertation is to demonstrate that social support is a necessary benefit which merits strong consideration to be offered to every first-time parent. I have developed an assessment interview and protocol to demonstrate that, although social support should be universal, varying degrees of needed support is more efficient, cost effective, and potentially is a more useful framework. For this study, I have purposefully selected couples who are

considered to be well functioning and non-problematic, and who anticipate an uncomplicated delivery to demonstrate their varying levels of stress, anxiety, ambivalence, and joy throughout the pregnancy, birth, and during the immediate post partum period. I have further set out to demonstrate that first-time parents are not instinctively equipped with knowledge of newborn care and breast feeding techniques. This dissertation clearly supports the notion that transitioning into the parenting role can be stressful. In addition, this study demonstrates the benefits of social support and ways in which its provision assists the couple's transition.

The theoretical foundation of this work is based on Uri Bronfenbrenner's Ecological Theory of Human Development (1979).

The ecology of human development involves the scientific study of the progressive, mutual accommodation between the active, growing human being and the changing properties of the immediate settings in which the developing person lives, as this process is affected by relations between those settings, and by the larger contexts in which the settings are embedded (Bronfenbrenner, 1979, p.21).

Bronfenbrenner's theory (1979) focuses on an individual's perception of, and adaptation to his environment and the changes that occur within it. Further, it focuses on the reciprocal relationship between systems, rather than on the properties and process characteristics of any one system. He believes that the researcher should illuminate patterns rather than parts. "Context, which is almost infinitely variable, determines content" (Bronfenbrenner, 1979, p.8). Thus, this is a theory that emphasizes naturalistic methods of inquiry, observation and research.

It is in this light that I have organized this research study. The approach that I have undertaken for this research project is congruent with an ecological theory advocated by Bronfenbrenner.

The qualitative assessment interview was designed in order to capture

the personal experience of the participants. It is an interview that helps to enlighten others about the ways pregnancy, birth and transitioning into the parenting role impact on the individual, the couple and the extended family within the context of their immediate environment. Through their narratives the participants have shared their experiences. They have voiced their anxiety and exhilaration. They have described their stress and their ability to cope. They have acknowledged the benefits of social support and the disappointment when the support wasn't available for them. They have generously offered suggestions and ideas to others who will walk the future path of pregnancy, birth, and transitioning into the role of parent.

Chapter I provides the foundation for understanding the necessity of providing social support in the immediate and early post partum period. The review of literature includes the psychological process that individuals experience during the pregnancy and, ultimately, as they transition into the parenting role. A description of the physiological process related to the post partum recovery is included to demonstrate further the rationale for placing some degree of emphasis on this particular phase of child bearing.

Chapter II outlines how policy and politics have shaped the birthing process and in particular how both have helped to erode provisions of social support. A Caucasian Eurocentric Historical Perspective traces the changes that occurred at the end of the nineteenth century and throughout the early part of the twentieth century in order to orient the reader and lend a clearer understanding of why the practice of obstetrics has changed. Included in this chapter is the discussion of recent policies and legislation that continue to attempt to shape the child bearing experience and impact on social support.

Chapter III discusses the research design and methodology used for this particular project. This ethnographic study employed fifteen couples, assumed

to be well functioning and non-problematic. At the time of the first interview, all of the women were in the last trimester of their pregnancy. At the end of the first interview I asked the participants to identify what kind of support that they felt they would need in the immediate post partum period. In addition I provided them with a list of formal support options. I encouraged them to select the options they perceived would be helpful to them in the immediate post partum period. The couples were interviewed one month after the birth of their baby in order to assess the post partum support they received and their level of satisfaction with it. Questions pertaining to what would have been helpful were posed in order to develop ideas for support measures that would be helpful to future childbearing couples.

Chapter IV discusses the results of this research project. The couples who participated in this study discussed their lack of knowledge related to newborn care and breastfeeding techniques. They discussed the sheer exhaustion, the frustration, the exhilaration and the struggles they encountered as new parents trying to regain a sense of equilibrium. Those couples who received support from family, friends and professionals clearly stated that the assistance they received helped them during the transitional process. Many expressed the wish that the support of a home visit from a professional could have been longer lasting and/or more frequent. This study also highlights that although plans for social support are arranged by a couple, they can go awry. This phenomenon supports the ecological perspective of Vaux (1988), who advocates for a plan that includes both informal and formal support. Several of the couples who had arranged for family support were disappointed when it didn't materialize. Others were disappointed when the anticipated support was not what they had envisioned. Several of the couples developed unanticipated post partum complications, while others experienced some medical problems

related to their infant. These situations created additional stress on the family unit and impacted on their transitioning process.

The couples clearly identified a definitive post partum time line. The majority of couples felt less prepared for the post partum phase. Most agreed that their childbirth education class was one resource that should have devoted some anticipatory guidance related to the post partum period.

The participants clearly articulated their experience during the assessment interview. The elements included in the interview were effective in capturing the individual experiences, which could be scored on the assessment protocol. The Assessment Protocol, designed to determine the degree of support a couple would need in the immediate post partum period, proved to demonstrate some degree of accuracy.

The concluding chapter contains recommendations for adjusting the assessment tool, implications for further study, and a suggestion to develop a universal post partum support policy as well as a national paid parental leave policy.

Chapter I

The Transition to Parenthood

Transition to Parenthood: An Argument for Support

Parenthood is a state of being, a rite of passage--a life stage. It encompasses the spectrum of emotions and experiences you encounter as you take care of your children and yourself (Plutzik, 1983, p.38).

Physiological Perspective

In order to appreciate the enormous task of transitioning into parenthood one must have some understanding of the rapid physiological changes that occur within the newborn mother in a relatively short period of time. The post partum period is identified as a six week period beginning with the delivery of the placenta. It is characterized by significant anatomic, physiologic and endocrinologic changes as the woman recovers from the stresses of labor and delivery and is confronted with the onset of lactation. In essence all the changes that occurred during the nine months or forty weeks of pregnancy will be reversed, some within the first ten to fourteen days after delivery (Blackburn, 1992). These changes coupled with the physiological exhaustion usually experienced in the birth of one's first child places an inordinate amount of stress on the woman who is now undergoing major psychological, social and role changes as she attempts to become acquainted with her new baby, assume responsibility for the care of her newborn and incorporate this baby into the family system (Blackburn, 1992).

In six weeks the size and position of the uterus will dramatically change. The weight of the uterus will drop from 1000 grams to 60-80 grams. Within days after delivery the uterus can be palpated and is located between the umbilicus

and symphysis pubis. By six weeks post partum it will return to its original position in the "true pelvis" and can not be palpated. Three processes contribute to this phenomenon, 1. uterine contractions, 2. autolysis of myometrial cells and 3. regeneration of epithelium (Blackburn, 1992).

Within thirty-six hours post partum there is approximately a 50% decrease in hormone levels such as progesterone and estrogen coupled with the onset of oxytocin and prolactin.

Blackburn appears to understate the post partum changes that women experience.

For most women these changes occur almost unnoticed, yet they provide the backdrop for the new mother's physical function and sense of well being and may influence adaptation of the woman to her infant and new role (Blackburn, 1992, p.152).

It is worth noting that increasing numbers of health insurance plans have adopted a twenty-four hour post partum discharge policy for "uncomplicated" deliveries. Very little forethought is given to these dramatic changes described. The thought that the provision of emotional and physical support might assist the woman and her mate in making the transition to parenting a smoother and satisfying process does not compute in a disease oriented medical model. Contemporary mothers are presented with logically inconsistent messages. They are told that their mothering "work" is noble and important, but they observe few males interested in taking on the work. In addition they experience little in the way of support services to carry out this noble work (Goodnow, 1988). I might add that they receive little support to assist them as they transition into the parenting role.

Parenthood and Parenting

Parenthood is a role, a career, a defining activity; parenting is an intimate, evolving and demanding relationship of deep impact. Parenthood affects identity; parenting influences intimacy (Shanok, 1990, p.3).

Theorists Erik Erikson and Grete Bibring include parenthood as a normal life crisis. They suggest that this crisis or life marker challenges both the inner and outer resources of the individual. It affects the intimacy and identity capacities of each partner (Shanok, 1990).

Gladieux notes that in the psychoanalytic literature this period is described as necessarily turbulent, psychologically disequilibrating, producing predictable intrapsychic and interpersonal turmoil (Gladieux, 1978). Cowan and Coie join Gladieux in the notion that a couple experiences disequilibrium.

The birth of a baby is one facet of a complex process which involves changing identity, role behavior, and communication patterns among three generations of a family (Cowan and Coie, 1978, p.298).

They suggest that this disequilibrium may lead to stress, crises or even dysfunction and yet may be a necessary component for developmental growth. Ooman Mammen, M.D. supports the notion that transitioning into the role of parenthood can be so disequilibrating that it can even lead to dysfunction.

During the post partum period, women are more likely to suffer from severe psychiatric illnesses which require hospitalization than any other time in their lives (Mammen, 1993, p.2).

He believes that there are many factors that contribute to this occurrence which do not discriminate socioeconomic strata or ethnicity. The factors identified include: the precipitous drop in estrogen levels immediately post partum; the absence of community support for new mothers in the post-industrial world; conflicts over division of labor in the family; and the psychological adaptation process of assuming the role of mother (Mammen, 1993). Alley and O'Donnell (1996) investigated depressive disorders ranging from mild "maternity" blues to psychosis. They found that although hormonal changes, stressful life events and personal family history may be possible causes, most affected women have no apparent risk factors. In contrast a study

conducted in China which recruited 129 Taiwanese women six weeks post partum revealed four predictable criterion for post partum depression: 1. low self-esteem, 2. lack of social support, 3. perceived stress, and 4. unplanned pregnancy (Chen-Ch, 1994). Dr. Mammen stresses that many of these disturbances are transitory. He points out that

Clinicians working in this area are uniformly struck by the number of competent and previously well adjusted women who develop severe post partum psychiatric illnesses and then go on to make excellent recoveries (Mammen, 1993, p.2).

It is important to note that these "well adjusted" women received maximum intervention in order to make excellent recoveries. That intervention often includes an in-patient hospitalization and on-going psychotherapy. In addition these women are nurtured and their caretaking efforts are encouraged, supported and validated. It is important to note that Dr. Mammen's in-patient program includes the infant during the mother's hospital stay.

Developmentalists Jay Belsky and Michael Rovine (1984) specifically identify three interrelated causes of stress for the newborn couple. They focus on the excessive physical and emotional expenditure of energy required during pregnancy and especially during labor and delivery that compromises the couple's strength, followed by the energy directed toward the care of their newborn in order to meet his/her demands. Lastly, the stress is exacerbated by the modification of a couple's everyday patterns of cognitive and behavioral functioning (Belsky, 1984). The more recent work of Belsky continues to highlight chronic fatigue and exhaustion as a major contributor to anxiety, depression and low self esteem experienced by new mothers. "Fatigue and physical weakness create a vulnerability to sharp and unpredictable mood swings" (Belsky, 1994, p.27). During a time of psychological vulnerability and uncertainty, important alternatives begin to occur in at least three primary areas

of a couple's relationship. 1. the psychological sense of self 2. role behavior and 3. communication patterns. "A new person in the home throws the whole home off balance, so you have to keep catching your balance" (Cowan and Coie, 1987, p.320).

The process of re-organizing requires energy and active problem solving efforts that lead toward clarity, competence and a more optimal balance between partners (Cowan and Coie, 1978). "We struggle to comprehend the baby's existence, come to terms with our own metamorphosis and understand a partner who's also not him/herself" (Plutzik, 1983, p.38). Parenting is hard work. It is not static, but a process of constant adjusting and re-adjusting. One task as the couple transitions to the role of parent is a process of re-discovering and adapting their relationship as a couple within the new family structure (Plutzik, 1983). One couple described this process as horrible in the beginning. Like so many other women, one new mother identified her general appearance as one factor. In addition their life as a couple "doing things" had shriveled to doing "nothing". Since change usually involves loss, these changes bring about a sense of loss accompanied by feelings of depression, anger and guilt (Rose, 1989).

Review of the anthropological literature reveals little evidence of post partum depression. Stern and Kruckman hypothesize that post partum depression in the U.S. may result from the relative lack of social structuring of post partum events, the lack of instrumental support and aid for new mothers and the lack of social recognition of role transition for the new mother (Stern, 1983). In their investigation and observations of many other cultures, they were struck with the lack of childbirth and post partum rituals practiced by the majority of women in the U.S. "Although childbirth is universally similar physiologically, it is differently conceptualized, structured and experienced" (Stern, 1983, p.1027).

They believe that the experience of post partum depression in non-psychotic forms is both exacerbated and cushioned by socio-cultural factors (Stern, 1983). Their inquiry of other cultures revealed common elements in the social structuring of the post partum period. Elements identified include: 1. cultural patterning of a distinct post partum period; 2. protective measures designed to reflect the vulnerability of the new mother; 3. social seclusion; 4. mandated rest; 5. assistance with tasks from relatives and / or midwives; 6. social recognition of a new social status through rituals (Stern, 1983, p.1027). The post partum period is frequently viewed as a time when the woman is especially vulnerable. Many rituals and functional assistance related to the care of the mother focuses around this idea of vulnerability and are aimed at re-establishing stability. Functional assistance is constructed around "protection from injury" in the form of economic and personal assistance such as child care, household work and the preparation of meals (Stern, 1983).

The important point is that the period is conceptualized as finite and different from normal life: in almost all societies it is a period viewed as 'recuperative' in which care is given to the new mother, her activities are limited and her needs are taken care of typically by female relatives (Stern, 1983, p.1036).

Time units are usually assigned to activities; a post partum period of forty days is common in Spain, Latin America, and Haiti. In contrast the U.S. loosely defines post partum as a period of two weeks as evidenced by expectations from the health care system that new mothers bring their baby to the pediatrician's office two weeks after delivery.

Stern and Kruckman (1993) observed that in some countries/cultures less attention is directed to the prenatal phase while a highly elaborated emphasis is placed on the post partum period.

In contrast to the post partum focus in other cultures the support experience of a new mother in contemporary American culture reflects greater concern for her before her baby is born (Kendall-Tackett, 1994 p. 3).

The emphasis on prenatal support is demonstrated in the prenatal check-ups, the prenatal classes, the baby shower and the emotional support by friends and relatives inquiring about her health (Kendall-Tackett, 1994). Mother-focused supports often decline after she has given birth and discharged within 24-48 hours.

The people who provided attention during her pregnancy are no longer there, and the people who do come around are often more interested in the baby (Kendall-Tackett, 1994 p.3).

Ann Oakley (1992) suggests that prenatal care has increasingly lost its component of care. She states that prenatal care has become a package of surveillance, monitoring and social control, which she believes is related to a patriarchal structure that contextualizes the way prenatal services are provided and used. Oakley stresses that focusing on the physical well-being of the mother and her baby are not enough. Her research highlights the lack of emotional support for women who describe their care as depersonalized, lacking physician continuity, receiving bland reassurance in place of information and subjected to the overuse of technologies such as ultrasounds and induction of labor (Oakley, 1992).

The belief that medical care is the best means to promote maternal and child health is congruent with a dominant ideology of our times--that health is first and foremost a medical product (Oakley, 1992, p.11).

Robbie Davies-Floyd suggests that American society, by transferring the birthplace from home to hospital, represents a de-ritualization of a process laden with superstition and taboo and has replaced it with another set of rituals established by the medical community (Davis-Floyd, 1992).

The dramatic shift from prenatal medical surveillance to post partum laissez-faire reduces post partum recovery to a trivial occurrence and reinforces the belief that parenting is an instinct.

Transitioning to the Role of Mother

The transition to motherhood is an event central to women's experience, setting in motion a complex process of change in both inner and outer worlds. Arrival of a first child leads to shifts in identity, in intimate relationships and in roles and responsibilities (McCannell, 1988, p.83).

Gladieux described some women who found that the transition to motherhood meant exchanging a realm of proven competency and adeptness to one in which adeptness had not been established (Gladieux, 1978). Belsky's findings support Gladieux. He found new mothers doubting their parental competence, wondering if they were capable of providing love and understanding to their baby (Belsky et al. 1994). This phenomenon appears to be more the rule than the exception and contributes to the erosion of the newborn mother's self esteem and self confidence, creating a sense of failure and incompetence. Self confidence refers to one's ability to do something, assuming a cognitive process related to self evaluation. Self-esteem assumes a cognitive evaluation process and an affective value attached to that self evaluation, such as pride or shame. The demise of her self esteem and self confidence fuels existing levels of stress, anger and depression. Fatigue, weight changes, and loss of muscle tone are additional factors that contribute to a lowered self esteem (Rose, 1989). Maternal self-esteem is considered an essential component of mothering. It is said to influence one's general self-concept, and is reflected in the woman's ability to develop a mother-infant relationship. The general self appraisal of mothering is thought to contribute to a more positive level of self-esteem (Mc Grath, 1992).

A strong sense of self can facilitate a woman's passage through those crucial early months. Yet the weeks of physical and emotional isolation that follow childbirth can erode even the strongest egos (Rose, 1989, p.28).

The often isolated restriction with a helpless, demanding newborn can easily consume a mother with misgivings, both about herself and her situation (Rose, 1989). Belsky's research identified social isolation as a stress factor for new parents, but more so for new mothers. He reasons that most often men return to work, which extends their world beyond home and the new baby. However, he does not minimize the dramatic reduction in "extracurricular" activities that contribute to men's experience of isolation (Belsky, 1994). Rose stresses that some of the feelings of disappointment and depression experienced by the newborn mother are precipitated by mismatched expectations between post partum fantasy and post partum reality. During pregnancy women anticipate an idyllic relationship with their child, unaware and uninformed that in the beginning phase of parenthood there are few rewards to offset the physical and emotional demands of their newborn (Rose, 1989).

"In a society which promotes motherhood as life's greatest satisfaction, there is little discussion of the trials of being a new mother" (Rose, 1989, p.29). In a society which promotes motherhood as life's greatest satisfaction, there appears to be little thought, let alone discussion, about the need for support from a caring, nurturing *other*.

Lucille Newman suggests that in contrast to an extended family or kinship group structure

The nuclear family structure is one which may be relatively maladaptive for reproduction and one of the most difficult and stressful ways in which we could arrange to have children (Miller, 1978, p.145).

Rothman (1991) stresses that in our society an isolated nuclear family structure is aspired primarily by the middle and upper-classes while it has not been a reality for most Americans. I suggest that this 'ideal' has become more widely accepted by all the classes and practiced as the norm.

Transitioning to the Role of Father

I don't know what it's like to be a father, I've never had the experience, or anything that comes close to it. "I never even dreamed of myself being a father. I sort of envision myself being a totally different man once this baby comes. I get nervous and worried about this pre-future child. What is it going to be like to a father and yet there is no way I can begin to make sense of it. I just end up calming myself down about it saying, 'Don't worry' (Fraktman, 1992).

In conceptualizing this assessment it appeared critical to include prospective fathers. Howard Osofsky, M.D., Ph.D. suggests that little attention has been directed toward expectant fathers. Studies that have focused on expectant fathers appear to minimize the adjustment of *normal males* to pregnancy and new parenthood (Osofsky, 1982). Drawing from a pilot study and from his own obstetrical practice, Osofsky noted that men undergo considerable stress during the course of a pregnancy and subsequent delivery. He cites regressive tendencies, unresolved conflicts and general life circumstances as the predominant stressors described by expectant fathers. He highlights the expectant fathers' descriptions following the initial excitement and pride related to pregnancy, as "feeling strange", "not being themselves", and experiencing heightened worries about anticipated changes in their own lives as well as in their marital relationship (Osofsky, 1982).

Becoming a parent advances men to changes in their own development, changes in how they relate as a couple, and changes in how they view themselves in the world at large.

Pamela Jordan cites Deutscher's study of ten young middle class couples conducted in 1970 as one way to conceptualize the pregnancy experience (Jordan, 1990). Deutscher identified essential tasks that couples appear to undertake throughout the pregnancy experience. These tasks were divided into the three trimesters. In the first trimester he found the expectant couple discriminating between sickness and pregnancy, shifting the pattern of nurturance and dependence within their relationship.

He proposed that this task began a "rehearsal" by which the couple explores their own and each other's sense of family and parenting styles, by "parenting" each other (Jordan, 1990). In the second trimester the "baby" becomes more of a reality, evidenced by fetal activity. The third and last trimester "brought greater distance between mates." This distance was offset by the couple's preparation for the baby represented by purchasing essential necessities for the baby as well as preparing a room or space for the baby (Jordan, 1990).

May, who examined the social-psychological experiences of twenty first-time expectant fathers, conceptualizes the pregnancy experiences of fathers in a slightly different manner. Although the results of her study support Deutscher's concept of phases or essential tasks, the focus of the task appears to be less congruent. Her study suggests three phases.

These phases mark shifts in the father's emotional and behavioral involvement in a first pregnancy and reflect the importance of the man's readiness(May, 1982, p.339).

May refers to readiness as the ability of the expectant father to transition into the parenting role.

Bench marks, showed as increasing emotional and behavioral involvement, signaling movement from one phase to another (May, 1982, p.339).

Phases identified by May include: The Announcement Phase which

signifies the suspicion and confirmation of the pregnancy, stressing the impact of the news on the couple. The Moratorium Phase represents the adjustment to the reality of the pregnancy on the father. This phase, most often reported, occurs between the twelfth and twenty fifth week. It appears to coincide with Deutscher's second trimester, evidenced by fetal activity. May identifies this phase as marked by man's emotional distance from the pregnancy (May, 1982). She stresses that men reported the pregnancy continued to be separate rather than integrated into their lives. They, however, reported the stronger emotional experience was the feeling of being "pressed" to confront the future (May, 1982). In the third phase, The Focusing Phase, men reported that they perceived the pregnancy as "real" and important in their lives. This phase usually begins around week twenty-five extending to the onset of labor. The major change in the attitude appears to be an increased focus on the expectant father's own experience of the pregnancy. Unlike Deutscher's third trimester, this phase marks an attitudinal shift that appears to draw the expectant father closer to his wife. The expectant father begins to define himself as a father within the context of the marital dyad. At the same time he begins to view the world from the perspective of a future father. May suggests that the process of focusing on the pregnancy and redefining his role as a father are connected. She suggests that the man cannot begin to identify himself in the role of father until he accepts the pregnancy and the impact it has on him (May, 1982). May concludes,

The process of redefining themselves as future fathers includes constructing an image of his future life with his wife and child (May, 1982, p.342).

Philip Cowan elaborates on this necessary integration process. He stresses that "integration is achieved only by grappling with conflicting sets of demands" (Bronstein, 1988). He identifies these demands as the father coming

to terms with his own identity in the work force and world at large, and his identity in the home. The struggle appears to focus on the man's ability to integrate aggressive and assertive behaviors more often displayed in the work place with empathic and nurturing behaviors relegated to one's home. The distinctiveness of these behaviors do not appear to be consciously apparent to the man prior to the pregnancy. Cowan points out that the struggles with issues of personal identity were less marked in men remaining childless during the course of his longitudinal study (Bronstein, 1988).

Carolyn Pape Cowan supports the idea that assuming the role of parent is a time of stress and potential crisis for the couple. She states that expectant fathers report that they feel somewhat isolated as they become more aware of changes that they are experiencing. These changes are described as a shifting perception of self, spouse, parents and friends. They report an increase in marital conflict and disagreement with less satisfaction in the role of couple. Men with lower self esteem expressed feelings ranging to unreadiness in assuming the parenting responsibility to experiencing symptoms of depression (Bronstein, 1988).

Daniels, Weingarten and Nydegger found that older expectant fathers exhibited greater role maturity. The older expectant fathers defined their role with distinctiveness and sensitivity to role expectations, potential role conflicts and competing time demands (DeLuccie, 1991). Fathers who reported a greater intensity of adult concerns felt less confident about their ability to fulfill the father role (DeLuccie, 1991). There appears to be a clear association between life concerns and negative child rearing orientations. This data appears to suggest that the father's ability to effectively cope with age related life strain may serve as an indicator of his ability to cope with the strain of pregnancy and new parenting. The level of maturity, competence and self esteem directly impacts

on the effectiveness in which the father develops coping strategies with these stressors (DeLuccie, 1991).

Pamela Jordan identifies men laboring to perceive the paternal role as it relates to their own sense of self and the roles they assume. Men labor to incorporate the paternal role into their sense of self-identity. They struggle to make the pregnancy a reality; they struggle to be recognized as a parent, different from husband, provider and friend (Jordan, 1990).

The most consistent and compelling theme throughout the literature review is that, although pregnancy is desired and welcomed, it brings about unexpected stressors represented as anxiety, life concerns, and demands to change.

Jerrold Shapiro, Ph.D. describes expectant fathers being caught in a double bind; his presence and involvement in the pregnancy is requested, encouraged and often demanded, but his feelings of fear and uncertainty are unwelcome (Shapiro, 1987). Shapiro's interviews with expectant fathers revealed similar anxieties and fears previously identified. All the fathers he interviewed expressed feelings of isolation along with feelings of stress and upset. The fathers felt silenced by the health care providers if they attempted to communicate their affective experience, especially if the experiences were viewed as negative or potentially upsetting to their partner. Shapiro states,

As men become more involved in the process of fatherhood, we must expand our understanding of their needs and fears. The father-to-be cannot be fully a part of the pregnancy and birth unless these fears are fully recognized by himself, by his spouse, by his family, and by society in general (Shapiro, 1987, p.42).

Support: Mothering the Mother

Prospective parents in the late twentieth century are dazzled by increased levels of technology, reassured by birthing rooms that suggest the

comforts of home, while at the same time they become more nuclear and isolated. As they pride themselves on being more self reliant and independent, they quietly struggle in their new role as parents, co-opted by policies established by "scientific " research and the dominant culture and entrapped in the myth that they are supposed to know what to do Braverman suggests, "What makes myths myths is their power to create reality" (Braverman, 1989, p.238). She contends that the myth of motherhood organizes women, families and society as a whole. She suggests that what may keep women tied to the myth is the satisfaction they receive from fulfilling it rather than the aggravation of opposing it (Braverman, 1989). She reminds us that the myth is more often an issue for white middle class women (Braverman, 1989). I would suggest, however, that those not sharing that status aspire to be tied to the myth.

The supportive role historically played by extended families has been slowly eroded by physical distance as well as by differences in child care concepts across generations. The traditional parental mystique of a "good parent" who is self-sacrificing has led women, in particular, to equate self-care with selfishness (Plutzik, 1983). Weingarten views this issue as the selfish vs selfless split. She suggests that women who are selfish are labeled bad mothers and women who are selfless are labeled "good mothers" (Weingarten, 1994). Weingarten traces the history of this phenomenon to the western idea of the individual as a solitary, autonomous, self-sufficient entity, which gained rapid acceptance after the eighteen century revolutions. Individualism, however, was not extended to women. Women were assigned the role of the mother who supported the centrality of the individual by nurturing individualism in others. "Mothers were to seek not personal gratification but the selfless gratification of caring for others" (Weingarten, 1994, p.64). Women were to practice this ideal primarily in the home, caring for their husband, children and property. Females

were taught that the ideal feminine goodness was selfless care for others (Weingarten, 1994). Although the woman's movement in the 1970's and the current research in the field of woman's studies has helped to erode some of this ideology, it none-the-less still exists and impacts on how well women accept support and nurturing for themselves.

Plutzik stresses that commitment to one's child must co-exist with a commitment to one another as a couple and to oneself as an adult. This endeavor requires striking a balance between responsibility to one's child, oneself and one's partner (Plutzik, 1983). One critical aspect of this process is the individual's perception of worthiness or a sense of personal importance that warrants nurturing (Plutzik, 1983). Plutzik feels that this factor may be at the heart of one's ability to receive support. Cochran et al. concur.

Parents under stress need to perceive themselves as important before they can be expected to engage actively with those surrounding them on behalf of the child (Cochran, 1990 p.260).

Dorr stresses that support from one's spouse, one's extended family, friends, and neighbors can be crucial in minimizing the sense of isolation or depression. In addition it can serve as reinforcement for her efforts at mothering (Dorr, 1981). She emphasizes her point. "The importance of practical and emotional support for mothers cannot be overstated, especially in the early stages of mothering (Dorr, 1981, p.56).

Crnic and Greenberg's study suggest that the effects of social support on maternal functioning are greatest during the early post partum period, and extending up to four months post partum (Crnic, 1987). This finding of four months appears to be congruent with Mercer's earlier research. First-time parents were asked what helped them get through the first six weeks of post

partum. They identified support rendered by one's partner, family, and friends, especially those who had given birth a few months earlier. Support groups were another source of support (Plutzik, 1983).

A well functioning social support framework usually provides information that one is cared for, valued and a member of a network of mutual obligation (Crnic, 1987, p.26).

In their research with middle class mothers, Vondra and Belsky found that feeling supported by their partner, family and friends is a predictor of increased sensitivity toward one's infant (Vondra, 1993).

It is apparent that perceived negative life stress and various types of support influence maternal attitudes, satisfaction and behavior toward infants (Crnic, 1987, p.31).

It is also noted that perceived maternal stress and support influenced the infant's interactive behavior with the mother.

Mothers with increased support are more satisfied with their babies, their parental roles, their lives in general and are more positive in their behavioral interactions with their infants (Crnic, 1987, p.31).

In the unpublished Doctoral dissertation by Cutrona, perceived inadequacy of social support was found to be a strong predictor of depression for first-time mothers from the last trimester of her pregnancy to the second month post partum (Mc Cannell, 1988). Additional research has demonstrated that a mother's satisfaction with support received from her spouse/partner, and community/neighborhood were significant indicators of positive maternal attitudes (McCannell, 1988). Earlier findings of Belsky are consistent. He found that a husband's supportiveness and positive regard for his spouse's mothering enhances the woman's ability to mother. Similarly, fathers who felt supported by their wives had a high sense of parental competence regardless of the infant's temperament (Belsky, 1984).

With a supportive partner and satisfying relationships the individual gains in emotional resources and in reinforcement of selfhood (Vondra, 1993, p.10).

Crockenberg's research with adolescent mothers reveals a relationship between the availability of social support and positive maternal feelings and behaviors. She noted that mothers receiving social support from their families appeared to be more responsive to their infant's cues and more involved in their care. In addition these mothers listed specific areas of support that they received from professionals that contributed to their overall maternal ability. The three highlighted areas were (1) listening (2) encouragement and (3) advice giving (Crockenberg, 1987, p.15). Crnic and Greenberg's study demonstrated that the intimate support of the spouse produced the strongest, most consistent and predictive relationship to maternal functioning (Crnic, 1987). Koeske has found consistent evidence that social support is a stress moderating resource (Koeske, 1990). Oakley(1992) has traced the history of social support and more importantly, its benefits. Based on her historical review and her own extensive research she is convinced that social / emotional support is a mediating factor in maintaining well being and health. Clearly the literature strongly suggests that support can be an important buffer for stress and even post partum depression as one transitions into the role of parenting.

Factors that influence the effectiveness of the support include accessibility, kinship reliance, frequency of contact, stability and most importantly the perception of the support received (Thoits, 1982). Belsky cautions that support is mediated by the parent's own psychological well-being. He stresses that it is the combination of internal and external resources that make the demands of parenting more manageable (Belsky, 1984). Having a greater support network may not always prove to be better. Using some index to measure the perceived appropriateness or satisfaction with available supports

seems critical in determining its optimum benefit (Crnic, 1987). Alan Vaux, Associate Professor of Psychology at Southern Illinois University, cautions about thinking of the intimate relationship as central to social support, which he believes is too restrictive to capture all that is deemed important. The notion of enlisting social networks is more plausible. Vaux suggests using an ecological model of support. From this perspective support is seen as embedded in existing networks of relationships, including professionals. The ability to help one another is emphasized. Professional services are seen as a technical supplement, not a replacement. Professional knowledge and techniques may be shared within the context of empowering.

The primary goal from an ecological perspective is the enhancement of support system functioning and the enrichment of support resources (Vaux, 1988, p. 239).

The advantage of this support model is that it is inclusive. It enlists family and friends because they share cultural values and understanding of the person they are supporting. This model also enlists additional support from "outside" of the group in order to preserve the system rather than pushing or stressing it beyond its ability (Vaux, 1988). He stresses that there are three major functions of social support: 1. It should provide supplementary assistance to the individual who is dealing with demands and who aspires to achieve goals; 2. it should sustain feelings of being cared for and valued and; 3. it should sustain a sense of social identity and social location. He stresses the importance of protecting and nurturing autonomy without undermining efficacy (Vaux, 1988).

One finding suggests that parental self confidence is derived in part from the support of key network members and is identified as an ingredient needed to stimulate network building (Cochran, 1990). Crnic and Greenberg agree. They suggest that even though social support on its own may carry some direct

causal effect, it may also serve as a proxy in enlisting the strengths of the individual mother, e.g. social competencies, coping resources and personal characteristics (Crnic, 1987). According to Cochran's research a parent's level of education assists in one's network building skills and one's ability to access people outside the kinship circle (Cochran, 1990).

Thoits (1982) maintains the position that the timing of support may be the critical factor. She contends that most studies measure support after the occurrence of life changes or during the course of on-going stress, which, then, questions the validity of the buffering hypotheses.

The obvious solution to this problem appears to be the determination of support levels before life events have occurred (Thoits, 1982, p.150).

She believes that this approach, which is preventative by design, may reduce the likelihood of undesirable life events from occurring. She suggests that attempts should be focused on improving and strengthening social supports rather than reducing exposure to stressors (Thoits, 1982). Belsky supports this concept. He stresses the importance of determining the degree of support to be provided by each subsystem and its constituent components rather than focusing on the reduction of stress (Belsky, 1984). Crnic and Greenberg suggest that careful assessment of parental support systems should be individualized to meet the specific needs of parents. They stress the importance of exploring the conditions under which various levels of support operate most effectively (Crnic, 1987). A multidimensional, individualized approach to social support appears to be the framework to employ when considering a universal social support model.

If support is related to disorder directly then a case could be made for promoting support among the general population, not just those at high risk for stressors. If support was seen as meeting basic social needs, promoting it among only high risk groups might ignore the majority of potential beneficiaries (Vaux, 1988, p. 243).

Chapter II

Policy and Politics

The Conspiracy Against Women and Children

How has policy shaped the attitudes, practices and values of women, and their pre-natal, perinatal and post partum experience? Mary Frances Berry traces the politics of parenthood throughout the history of this country. She maintains that the idealized traditional family is a modern invention. She argues that research and theories about gender roles, child care and infant development encourage us to cling to the mother-care tradition despite the economic burdens women face (Berry, 1993).

The predominant themes related to mothers, infants and families that have been shaped by policy include the value placed on "mother's"/ women's work, economic independence and keeping women in their place vis a vis control and decision-making power. Embedded in these themes is how and where women give birth and who is in charge of the birthing event.

A Caucasian Eurocentric Historical Perspective

Prior to the early 1700's in white America, childbearing conferred a certain status on women. "New mothers were pampered for as much as a month, the center of attention among friends and family" (Scholten, 1985, p. 9). Pregnancy was considered an ordinary event, childbirth an open event assisted by midwives and an audience of females. "After delivery the mother was covered up snugly and confined to her bed, ideally for three to four weeks" (Scholten, 1985, p.27). The rationale for this practice was to support the new mother in order for her to regain her strength after a debilitating experience, namely labor and delivery. The role of midwives was a supportive one. They offered encouragement and comforting advice along with herbal remedies rather than any overt interventions during the laboring process (Levy, 1992).

With the threat of witchcraft charges during the 1600's and 1700's, barber-surgeons, men trained to use surgical instruments, were called in to intervene when difficulty arose in the birthing process and a woman's life was in danger. After women gave birth, midwives continued their support by assisting the mother with infant care and household chores (Levy, 1992).

Since no medical schools or hospitals existed in America during the 1750's, American upper-class men began to study medicine abroad. The Parisian schools developed a concept of birth that appeared rationalistic and mechanistic, equating the womb to that of a pump. The premise of this belief can be traced to Rene Descartes who conceptualized mind-body dualism. Descartes described the body as a machine, the structure and operation which fell within the domain of human knowledge and in direct contrast to the mind, which God alone could know (Rothman, 1991). The Cartesian model operates to make the physician a technician who provides technical solutions to technical problems.

This approach to the body as a machine, found in the medical model, both comes from technical/industrial society and reflects that society, shaping it and its members (Rothman, 1991, p. 35).

Their simplified idea of the womb as a pump disassociated childbirth from a social, spiritual and emotional experience and made it a medical event (Levy, 1992). Since the midwifery model presents an integrated or holistic approach of mind-body dualism the services of midwives were unwelcome and determined unsuited for the new scientific technology.

Toward the end of the 18th century and the beginning of the 19th century two distinct changes began to occur: (1) American women, especially white middle class urban dwellers, had fewer children and (2) the distinctly feminine character of childbirth began to be usurped by men trained in medicine who began to study midwifery. The argument for this latter change, promulgated by

physicians, stressed that childbirth was a dangerous and delicate process requiring the expert assistance of a physician. At the same time women were denied access to formal training in obstetrics (Scholten, 1985). There are several factors that explain why physicians usurped the female-led practice of midwifery among well-to-do urban women in the late 18th and early 19th century. Those factors include the formal education of American physicians, the development of midwifery as a science, the utility of midwifery as a means of building a physician's practice and the desire of women to receive the "best" help in childbirth. Lastly, the massive social changes associated with urbanization and industrialization appear to have solidified the belief that physician-assisted births were the optimal method of delivery (Scholten, 1985). Rothman suggests that physicians' near-complete ascendancy into obstetrics socially defined their role as experts, first in the management of difficult or abnormal births and eventually all births (Rothman, 1991). Rothman suggests that physician-assisted births were, in fact, not providing the best services (Rothman, 1991).

Without any governmental or societal effort to develop schools of midwifery, and with numerous barriers arising to their access to tutors, by the nineteenth century, midwives primarily practiced among the poor and disenfranchised. (Walsh, 1991, p. 6).

The eventual disqualification of midwives resulted from competition for patients, fees and power.

During the course of the late 1800s through the early twentieth century, medicine gained virtually complete control of childbirth in America, beginning with the middle class and moving on to the poor and immigrant population (Rothman, 1991, p.57).

In a dwindling childbirth market physicians began servicing the poor and immigrant populations in order to insure practice and training opportunities.

If poor women continued to seek midwives for their confinements, student doctors would have no one to practice and midwives would continue to constitute real competition (Eyer, 1992, p. 135) .

By the mid 1800's women began giving birth in hospitals. The rationale for this change included the use of anesthetics and pain relieving medications, the belief that hospitals were more "sanitary" than homes, and the dramatic decline in the number of practicing midwives (Levy, 1992). Levy suggests that the replacement of the social, sexual and emotional experiences of childbirth by a dehumanizing hospital environment with complicated technology has reduced childbearing to a physiologic function which is viewed as dangerous and perhaps pathological. "This model gives the illusion that doctors 'deliver' babies instead of women 'giving birth' to their babies" (Levy, 1992, p. 84).

These developments provide insight into the changing condition of white middle and upper class women in American Victorian society. These events influenced the change of family life patterns for this particular socio-economic group to small, emotionally intense units where mothers came to be regarded as the most important parent, absolved from direct economic responsibility, in order to concentrate all their energies on the "beautiful work" of motherhood. The decrease in birth rate elevated the women's role as mother into a sacred calling and child nurturing as an all absorbing task. This model was to become idealized and universalized, one which most families strove to achieve.

Paradoxically, the growing emphasis on motherhood as women's greatest task in life, and the conviction of mothers' profound influence on their children, gave women more importance at the same time as it bound them more firmly to their homes (Scholten, 1985, p. 96).

Women's role in assisting women through labor and delivery was usurped by male physicians. The place where women gave birth changed from the home and familiar surroundings to an unfamiliar setting, the hospital. The holistic approach to labor and delivery provided by midwives has been

replaced by a pathological model using high technology and medical professionals who claim to know what is best for the "patient." Post partum rituals have become absent with no replacement except isolation and the expectation that one should know what to do.

Hospital Policy

The American practice of obstetrics has warped the birth experience into a pathological event. Outwardly, medical science does not define pregnancy and birth as pathological events, but rather defines its role as providing contemporary solutions within a disease orientation. The on-going message, however, is that pregnancy and the birthing process are dangerous and hazardous to both mother and fetus. This danger necessitates the use of high technology and physician-attended births within the hospital environment. The concept of "risk" serves as the centerpiece in the debate about appropriate childbirth practice. This concept appears to be essential to the maintenance of an orientation to birth as a medical problem (Reissman, 1986). Physicians, members of the American College of Obstetrics and Gynecology, were strongly encouraged to insist on exclusive decision making power to avoid malpractice claims (Edwards, 1984). This position has been supported by policies initiated by physicians, perpetuated by hospital administrators and presently directed by health insurance mandates. The notion that pregnant women are treated as sick and are labeled patients has allowed childbirth to become a surgical procedure, under medical control (Rothman, 1991). Hospital policies have organized a routine, or one could say a ritual, for women in labor that is often dehumanizing, isolating and often in direct opposition to the normal natural physiological process of labor and delivery. Diony Young, health educator in New Zealand and consumer advocate, states that,

A satisfying childbirth experience appears to create in the mother an increased self-esteem and self-confidence that, in turn, can foster positive feelings toward her baby (Young, 1993, p. 3).

An Increasing amount of sophisticated technology continues to perpetuate the pathological model of pregnancy and birth. This technology helps to foster new policies and continues to exert control over women and where the birth event will occur. There appears to be a focus on the production of the "perfect baby," which Davis-Floyd believes is a direct result of the combination of the technocratic emphasis on the baby-as-product and the new technologies available to assess fetal quality.

"Birth is thus a technocratic service that obstetrics supplies to society; the doctor delivers the baby to society" (Davis-Floyd, 1992, p. 57). She points out that physicians are credited if the product is perfect, if flawed, responsibility will ultimately be assigned to the inherent defectiveness of the mother's birthing machine. Women, during the course of their pregnancy, are categorized as "High Risk" or, if appearing to have all the healthy characteristics of a "normal" pregnancy will be classified as "Low Risk" (Rothman, 1991).

Davis-Floyd developed some conceptual dilemmas which foster policies related to pregnancy and birth and illuminates the rationale for the lack of post partum support. She states that our society is conceptually grounded in the technocratic model of reality with a strong vested interest in maintaining that model (Davis-Floyd, 1992). That strong vested interest, one might conclude, is male dominated and financially driven. There are strong rewards for high technology. The rewards are reciprocal. In an age where hospitals are struggling for survival in the competitive medical market, the trend and use of high technology attract physicians and their patients to hospitals. In order to continue to lure physicians and patients, hospitals acquire new machines and new technologies that advertise safer and more positive birth outcomes.

The partnership is further supported by a medical insurance system that rewards the use of costly technology and surgical interventions and penalizes those who choose more conservative methods (Edwards, 1984, p. 191).

Home births are one example. Many insurance companies will not reimburse the midwife if the delivery of the baby occurs in the home.

Davis-Floyd points out that the institutions and technology are inherently asexual and impersonal, which is in direct opposition to the birth process which is inherently sexual and intimate. She reminds us that the white, male dominant culture has continued its strong need to have dominion over nature, thus the continued attempts to exert control over pregnancy and birth, a natural process. This control is exerted through the use of hospital routines and technologies that attempt to eliminate the inconsistency and unpredictability of a natural birth process following its own course. One mother, who had home births for both her children, wonders and worries that the more routine technological birth becomes, the further mankind distances itself from members of its own species (Davis-Floyd, 1992). The technocratic medical model, with an end product, a baby, divests itself of emotional responsibility once the "product" is delivered. What this model lacks is the understanding that a new family system is formed, which includes an emotional, affective state between the mother, the couple and their interaction with the infant and each other. This new family system requires human contact for emotional, psychological and physiological support.

The emotional aloofness of the medical model makes it easy for hospital and health insurance administrators to design a discharge policy based on medical technocratic criteria, namely the termination of a pregnancy by an uncomplicated delivery. Medical technology transforms the way medical scientists think about human problems. Because physicians focus on the technology driven concept that the body is a machine, the idea of post partum

support is not even within the realm of physician orientation. Once the *physician* has "successfully" delivered the baby and both, mother and baby, are deemed well and normal the obstetrician's task is complete pending a follow up check-up in six weeks. An interesting contradiction exists. Throughout the prenatal and perinatal stages the medical model is strictly adhered to. Once the baby is "successfully delivered" nature and maternal instinct are assumed to take over. Mother and baby are now assigned to separate tracks. She visits her obstetrician/gynecologist and her baby visits the pediatrician or "well baby" clinic. The notion that the mother, father and baby may need "support" does not compute in this technological model (Riessman, 1986).

The phoenix-like quality of the medical model suggests that pressures will persist to view problems at the individual level and treat extant problems rather than try to prevent them (Vaux, 1988, p.238).

From this perspective social support will be seen as irrelevant or even a personal risk factor of minor importance (Vaux, 1988).

Anthropologist Sheila Kitzinger cautions that the manner in which a society treats its childbearing women is a powerful indicator of what the culture values, what is important, and who controls the place of birth. Clearly she has ascertained that male doctors are in charge. She laments that this control has impoverished the lives of women and cut the ties between generations. In addition, eliminating a continuity of female support has made women more vulnerable to professional control (Edwards, 1984).

Barbara Bridgman Perkins, an independent scholar in Seattle, Washington suggests, based on her research, that inappropriate intensity and stratified access to care exists in U.S. perinatal care. Toward Improving the Outcome of Pregnancy Committee (TIOP) defined levels assigned to hospitals according to technical capabilities and degree of physician and nurse specialization. With the growth of high intensity perinatal services came high

intervention rates requiring the use of Neonatal Intensive Care Units (NICU) Electronic Fetal Monitors (EFM) and surgical intervention.

Perkins noticed a discrepancy in the care and clinical interventions rendered to low risk women giving birth.

Low risk women giving birth in hospitals with high technical capabilities experienced more obstetric procedures than low risk women in lower level hospitals (Perkins, 1994, p. 19).

Perkins suggests that the structure of perinatal care re-enacts socio-economic stratifications in our society. Her premise is based on the fact that even though level III perinatal services, i.e. those possessing the most technological capability, have been geographically located in urban areas where more high-risk women reside, their capacity has been determined by their teaching and professional needs and not necessarily by its accessibility for high risk women (Perkins, 1994).

Hospitals with the subspecialists, the money and the political power have been more successful in establishing NICU units than many public hospitals serving higher risk patients (Perkins, 1994, p. 21).

The rationale supporting more technology has focused on safer, healthier outcomes. Henci Goer, certified childbirth educator and doula, has compiled a volume of abstracts of medical studies in obstetrics to dispel the myth that the implementation of technology enhances pregnancy and birth outcomes. Many of the studies focus on birth outcomes related to the place of delivery. A 1992 study written in the Journal of Midwifery comparing outcomes for women who delivered their baby in the birth center with women who delivered their baby in the hospital concluded that

Women giving birth in the hospital, even women with no complications, experienced many more interventions. This not only did not improve outcomes, but may have contributed to infant mortality (Goer, 1995, p.330).

In 1971 an "experiment" using midwives demonstrated a dramatic

reduction in premature births and neonatal deaths. In spite of these findings, funding for this project was terminated. Following the financial termination premature births and neonatal deaths increased. Nurse midwives were patient and fought for eleven years before receiving legal status (Edwards, 1984). Suzanne Arms, a photo-journalist and author of a ground breaking book on childbirth practices, challenges medical technology and procedures in her remarks.

That a profession which considers itself so advanced because of the very medical technology and procedures that are running the birth process for thousands of women across the nation, should so callously dispense with the very birth attendants who can reclaim the process for women and make it safer as well, is no less a shameful indictment of the medical fraternity in the United States today (Arms, 1975, p. 225).

The issue does not appear to be related to the welfare of women and infants. It appears to be directly related to money, power and control.

Interestingly, the adoption of a risk framework for managing birth is costly. Medical industries continue to refine technical equipment and market it to medical institutions who lure physicians and their patients with improved, expensive mechanized obstetrical units (Reissman, 1986). What continues to lack attention and certainly money is the post partum phase, bringing baby home! The Department of Consumer Affairs (DCA) suggests that the medical industry is concerned with providing health care for a profit. Prevention is not considered profitable (Edwards, 1984). Doris Haire, nationally recognized for her role as the American lobbyist for women and their unborn children, produced a monograph on international maternity practices in 1972. In her attempts to raise consumer consciousness related to maternity/obstetrical practices Haire came to realize that of the vast majority of funding for medical research in the U.S. has been customarily given to high technology projects. This, she laments, is at the expense of "medicine's most neglected stepchild, the

field of preventative health" (Edwards, 1984).

Keeping Women Economically Dependent

The notion of white women working outside the home continues to be a disputed issue. At the core of the issue is race, class, money and power.

Working women pose a threat to the established male authority and power. Partners who have their own income are more likely to develop their own sense of autonomy. A logical progression of attaining autonomy is sharing equal status with one's partner.

Over the last two centuries, scientists have persisted in asserting that women's natural maternal urges are subverted by educational, occupational or political aspirations, equal rights, divorce and birth control (French, 1992, p.152).

Studies, however, dispel this assertion. One nursing study partially funded by the McClaus Endowment Fund of the University of Washington, recruited 313 pregnant women, 50% who were employed and 50% who were homemakers. The purpose of the study was to examine the effects of employment on pregnant women's health and their ability to access support. The findings revealed that employed pregnant women expressed more positive health. Although both groups identified specific physical symptoms, those women who remained at home reported greater levels of depression, sleep difficulties and feeling afraid. Employed women effectively accessed support from their social network and were more satisfied with this support than were the homemakers. Women who were more likely to return to work within the first post partum year received greater support from their partner. Data from this particular study did not substantiate any detrimental effects from employment on pregnant women's health or their obstetrical outcome (Brown, 1987).

The women's movement appears to have started the pendulum of

change, opening avenues for women and expanding the possibilities for their personal and professional fulfillment. Economic demands, an increased awareness of women's capabilities, and greater accessibility for women in the work force and the academic arena have contributed to the gradual erosion of the traditional family model.

In spite of these changes, the politics of politicians with their influence on designing policies have continuously demonstrated efforts to maintain and idealize the traditional family model (Berry, 1993). Policies based on the traditional family ideology have limited women's chances to become independent or establish statuses that are not contingent on their partner's or male's status (Epstein, 1988). Arguments abound that strengthened family ties and values are the primary solution to America's economic difficulties, academic shortcomings, and increased violence throughout the country.

Focusing attention on family arrangements diverts us from the research, programs, and hard choices necessary to bring families back into balance with economic and political realities (Coontz, 1992, p.257).

This conceptual arrangement places limitations on women's physical potential, limitations on how they organize their behavior and limitations on how they are perceived and valued (Lewin, 1985).

When motherhood is understood to be prior to everything else, to be the essential condition against which other dimensions of the female experience are arranged, it becomes an environmental factor to which women must adapt (Lewin, 1985, p.124).

Politicians, theologians and military leaders often profess that the wealth of our nation is its children. Ironically, the creators of that wealth deserve no economic visibility for that work (Waring, 1988).

All the labor that goes into the production of life, including the labor of giving birth, is seen as an activity of nature, rather than as interaction of a woman with nature (Waring, 1988, p.29).

Since paid labor is productive, the United National System of National Accounts (UNSNA), which governs the measurement of national income in all countries, excludes household activities, which encompasses child care, household maintenance and production outside the UNSNA's production boundary (Waring, 1988). When women enter the paid work force their work is valued, more often, economically. Lewin, however, attempts to put that value within a social context. Not only are women in the work force segregated into the lowest paid and least rewarding domains of employment, they experience few opportunities for achievement and are structured into an ideology that promotes men's accomplishments as a primary reference group for women (Lewin, 1985). Female workers in America earn about 70% of what male workers earn constituting one of the largest wage gaps in the advanced capitalistic world.

The average woman worker's earnings peak at \$22,000 per year somewhere between the ages of forty and forty-four (Coontz, 1992, p. 260).

Coontz is quick to add that women's financial improvement is largely due to falling wages for men.

Research findings have indicated that low income leads to economic pressure which impacts and reduces the level of psychological well-being, which potentially reduces one's quality of parenting. In addition severe economic pressure diminishes involvement with friends, which may reduce social networks and directly limit one's access to social support (Simons, 1993; Oakley, 1992). Cynthia Gracia Coll's research findings support Simons and Oakley. She reports that, through research, socio-economic status (SES) has been repeatedly implicated in determining the characteristics of the caregiving environment and the developmental outcome of infants (Garcia-Coll, 1989).

Poverty

Ruth Sidel (1986) parallels the United States, considered "unsinkable," to the Titanic. She ponders how a state-of-the-art vessel equipped with the most lavish amenities held a mere twenty lifeboats with room for 1,178 out of 2,207 passengers and crew members. She informs us that the generally accepted protocol of "women and children first" appears to have only applied to first and second-class passengers. The higher percentage of women and children in third class were forcibly kept down below by seamen standing guard. Of the women and children in third class, 70% perished (Sidel, 1986). Sidel views the U.S., like the Titanic, filled with locks, gates, segregated decks and policies that assure that women and children will be first to fall into the abyss that is poverty. Amidst the almost unbelievable abundance in this country there is contempt for those less fortunate with the unfounded belief that economic deprivation is one's own fault. American antipathy toward the poor is fueled by remnants of the Protestant ethic which maintains that hard work is rewarded both monetarily and spiritually (Sidel, 1986). Social and political changes in the 1970's and 1980's exacerbated inequality and removed most of the rewards usually associated with the idea that "hard work pays off" (Coontz, 1992). What hinges on the economic reality is that poverty and class are gender specific discriminatory practices and in particular directed against women of color, Native Americans and immigrants.

One strong argument touted by politicians to maintain this unequal status is to idealize the traditional family model, which keeps women "in their place," economically dependent either on their spouse, a male figure or the government. The women in turn, are relegated to the care of children and men.

"Inequality is structural or socially patterned." Women of color are subordinated because patterns of hierarchy, domination and oppression are

built into the structure of our society. Opportunities in the labor market are influenced by who people are rather than what skills or abilities they possess (Zinn, 1994). The notion of the traditional model of mothers remaining at home with their infants and children is a white model. Women of color, immigrant women and Native American women are expected to "work" outside of the home.

Poverty and racism shape the daily lives of Native American women and children. Often within urban centers, they are segregated, separated as a lower caste and class group and largely dependent on some form of welfare (Joe, 1994).

"Nearly two-thirds of Native American families living in Tucson were receiving public assistance as their primary financial support" (Joe, 1994, p.195). On the one hand public assistance affords them a "safety net" from economic collapse, while on the other hand the amount they receive insures a life of poverty (Joe, 1994).

Poverty and oppression has caused many to feel hopeless, disillusioned and frustrated. In spite of this the African-American and Native American have demonstrated incredible strengths and resiliency. What has kept them afloat, as opposed to the Titanic, has been their connection with the family, their kinship groups and their tribe.

The values of Americans, for good or for ill, cut across race and class. Most poor and unemployed people desire to "make it" in middle-class society in much the same way better off Americans do (Coontz, 1992, p.271).

The universal practice of providing post partum support to every woman, infant and family unit is a social responsibility not only to the family, but, to the welfare of this country. What is determined important and of value is information embedded within the social practices of the culture (Bem, 1993). It appears by

the lack of provision for post partum support services for families in the immediate and early post partum period we, as a society convey that the family, and especially women and infants, are not valued.

The kinds of human beings that children and adults become depend on their daily social experiences, preprogrammed by institutionalized social practices, which are themselves but one embodiment of the same cultural lenses that are also embodied in cultural discourse (Bem, 1993, p. 140).

Alan Vaux's extensive review of social support attempts to illuminate the difficulty in arguing for its implementation . He suggests that within a scientific, quantifiable framework it is difficult to demonstrate the beneficial effects of social support. He describes previous studies confounding because of the choice of study that was examined, the inadequacy of methodological criteria or the way complex and inconsistent results are synthesized. He further rationalizes that it is difficult to integrate findings because the diversity of focus is based on either subjective appraisal, supportive behavior or components of the support network (Vaux, 1988). Ann Oakley (1992) argues that the dissemination of findings of social support studies is hindered by their threat to particular groups. She suggests that the documentation of health promoting effects of social support threatens clinical standing and expertise. She asks,

If listening to women's worries, visiting them at home and providing continuity of care are shown to be beneficial, then where does this leave the obstetricians, who generally do none of these things (Oakley, 1992, p. 328)?

She states that non-publication of papers regarding social support in clinical journals on the grounds of their irrelevance to clinical practice is further evidence of the resistance by the medical profession (Oakley, 1992).

What research interventions can be expected to accomplish in the field of reproductive care, is framed within the double vision of a culture which accords motherhood ideological importance while refusing to confront what it is about motherhood that makes it difficult: the unsupported labors of love; the poverty of caring; the struggle to work, in the home and outside it; the stress of trying to hold the social relations of families together (Oakley, 1992, p. 327).

Oakley(1992) maintains that the provision of sympathetic, listening support through continuity of care, which is safe, inexpensive, what women want, and works is a more effective way to promote women and infant health.

We can not afford not to develop and maximize universal post partum support options, opportunities and resources. Determining the degree of needed post partum support as a universal practice conveys the message that we, as a society, value families and understand that transitioning to the parenting role is stress provoking and hard work.

Improving the health status of mothers and children requires more than expanding access to care. It requires improving and reforming the content of that care (Kotch, 1992, p.182).

Chapter III

Research Design and Methodology

When considering a research project one chooses the method that one believes will best lend meaning to that body of research. For this particular research project a qualitative research method derived from grounded theory (Glazer and Strauss, 1967; Spradley, 1979) appeared to be the most appropriate. The design of this research project is embedded in Bronfenbrenner's Ecological Theory of Human Development, which involves the study of individuals as they progress and adapt to a changing environment , and to changing roles (Bronfenbrenner, 1979).

The purpose of this exploratory research project is to develop a support protocol based on an open ended qualitative interview. Unlike most medical questionnaires that tend to focus on a medical history, this interview focuses on the psychological, affective experience, and social adjustment of both partners to pregnancy and their anticipated need for post partum support. The interview is designed to elicit the strengths of each individual within the dyad, in order to better understand how they, as a couple, will transition into the parenting role and incorporate the baby into their family unit. The interview is also designed to elicit the post partum support that each individual perceives may be available to them as a couple in the immediate and early post partum period.

Kerry Daly, Assistant Professor in Family Studies, University of Guelph, Ontario, Canada, suggests that qualitative methods are versatile, rendering a better match for examining the diversity of families and their experiences.

With qualitative methods, the focus is not on identifying structural or demographic trends in families, but rather, on the process by which families create, sustain, and discuss their own family realities (Daly, 1992, p. 4).

Daly reminds us that families are one of the most closed and private of all social groups.

Qualitative methods give us windows on family processes through which we can observe patterns of interaction and the ongoing negotiations of family roles and relationships (Daly, 1992, p.4).

Qualitative research is congruent with Bronfenbrenner's Ecological theory because it emphasizes naturalistic methods of inquiry and observation. Bronfenbrenner (1979) stresses context and how its variability influences the process of adaptation and accommodation. Daly (1992) supports this perspective reminding us that process is the focus: the researcher observes and listens to the individuals as they describe their efforts to adjust to their experience. Bronfenbrenner's theory focuses on the person's perspective by listening to their account of that experience. Qualitative research lends itself to developing relationships and interacting with participants who are in their own natural setting, and may be more receptive to share their experiences in their own language, and disclosing information according to their level of comfort.. Qualitative research collects, analyzes and conceptualizes data represented by means of a rich, descriptive, interchange between researcher and participant. What better way can we, as health care professionals, understand human experience than by listening to one's personal narrative as they incorporate a new baby into their family system?

Sample

Qualitative methods leads to nonprobability sampling. The nonprobability purposive sample employed for this research project represents intact couples, who have been in their present relationship for at least one year, and who were prospective first-time parents anticipating an uncomplicated delivery.

Participants for this study were solicited through prenatal exercise

classes in several YMCA programs located in suburbs west of metropolitan Boston, by word of mouth, by response to a recruitment flier, or by the "snowball" method. Snowball sampling is a method through which one participant in the study is asked to recommend others for interviewing. This process is repeated, which can lead to an increasing number of participants (Babbie, 1986).

The fifteen couples selected deliberately represent what might be considered a privileged group. The purpose for seeking this particular group for the study sample is to dispel the premise that age, academic preparation, and economic status will insure a smooth transition into both the parenting role and the ability to breast feed one's infant. By employing this particular population I hope to strengthen the argument for universal post partum support. Intact couples are not free from the stress of transitioning into the parenting role or are they free from stress as they begin to incorporate the baby into their family unit. It is commonly argued, however, that this particular population will fare better than the "at risk" population. There may be some truth to this belief. Why is it that our health care system continues to let them struggle through this transitional process when research has demonstrated that social support helps to reduce stress and facilitates a smoother transition?

Sample Composition

Fourteen of the couples represented are North American, Caucasian, and one couple is African-American. Their educational level ranged from a high school diploma to doctoral preparation. It is worth mentioning that a bi-racial couple did not complete the interview process and are, thus, not included in this sample. However, reference regarding this couple will be made in the results portion of this thesis.

Demographics

Age Range	Women	Mean Age
	23-40	28.5
	Men	
	26-43	32.9

Age range Between Couples 0-5 years

Time Together as a Couple 1-9.5 years

Time Married 2 months-6 years; two couples remain unwed

Education

Women 4 high school plus some education, 1 Diploma in Nursing
2 Assoc. degree, 2 Bach. degree , 6 Master degree
6 participants are practicing nurses)

Men 4 high school plus some education/training; 5 Bach. degree,
4 Master degree, 2 beyond Master

All were dual income couples prior to the birth of their baby.

Eighty-six percent of the female sample [13] plan to return to their previous employment at the end of their maternity leave.

Thirteen percent of the female sample [2] plan to remain at home to work as full time mothers and one of the fathers changed his present employment to be the primary caretaker.

Sixty-seven percent of the sample [10 couples] had a planned pregnancy.

Thirty-three percent of the sample [5 couples] had an unplanned pregnancy.

Research Procedure

The qualitative interview was conducted in the third trimester of pregnancy. The rationale for this particular timing is based on the research review, which marks the last trimester as the period of time when the imminent arrival of the baby becomes more real. It thus appeared that discussing the anticipated need for support in the immediate post partum period would be more relevant in the last trimester. I believe that by the last trimester of pregnancy support provisions may have been discussed and/or were already in place. Thus the timing of this interview was an opportunity for the interviewer to

develop some understanding of the couple's perceived need for support.

I met with the prospective fathers in their home, with the exception of one, who met in my home. The prospective mothers were interviewed in their own home, with the exception of two; one met in my home, and the other met with me in her place of work. These sites were mutually agreed upon. The individual interviews were audio-taped and lasted from thirty minutes to one hour. All participants in the study read and signed an informed consent form. At the end of the interview each participant was asked to review a "wish" list of instrumental support choices and select any of the choices they perceived would be helpful to them in the immediate post partum period. Space was allocated for participants to write comments or additional perceived needs which were not included in the list of choices.

The information gathered from the qualitative interview was coded and assigned to a protocol, which I designed.

Tabulation of the Number of Indicators in the Protocol

Each item in the protocol contained subsets of attributes that were identified in the research that could be considered indicators for needed support in the immediate and early post partum period. These items were explored during the interview. If an individual identified alcoholism as part of the family history, for example, a check would be assigned to that particular characteristic. The identified attributes of the individual were combined to reflect a couple and their need for support. The total number of possible checks assigned to a couple could total $N=60$. The greater the number of identified items indicated a greater degree of necessary support in the immediate and early post partum period.

The range of predictable attributes is identified below.

1-15 items = Minimum Support Required

6-30 items = Moderate Support Required

31-60 items = Maximum Support Required

In the preliminary design, couples were to be randomly selected to receive supportive interventions based on their combined assessment score. This design proved to be ineffective due to delays in notification of birth arrivals from the first four couples. Attempts to provide post partum support to two of the randomly selected couples fell short of my planned expectations. Although attempts to adjust for this phenomenon were implemented, this specific portion of the design continued to be ineffective and was therefore abandoned.

The initial number (36) of proposed couples to be interviewed was reduced to 15 due to the enormity of interviewing 72 individuals and 36 couples and the difficulty in obtaining participants for this study.

Due to some of the difficulties described, the research design was adjusted. Babbie (1986) suggests that the advantage of qualitative research is its flexibility, which allows the researcher to make adaptations in the field.

The field researcher can continually modify the research as indicated by the observations, the developing theoretical perspective or changes in what he or she is studying (Babbie, 1986, p.254).

Rather than expecting couples to contact the researcher by phone, a self addressed stamped postcard was given to them at the end of the first interview. They were asked to mail the card to the researcher when they were discharged from the hospital. Participants were asked to fill out the back of the postcard, which had been designed to include the name of the baby, the date and time of birth, parents' names, and the date the couple arrived home. Compliance for this method was 86%. All fifteen couples (100%) were contacted. A one month

follow-up visit was scheduled at that time.

Reassessment

I met with the couple in their home one month after they and their new baby were discharged from the hospital. At that time I asked them what support they received immediately post partum, their perception of that support and what support provisions would have helped them in the immediate post partum period. This interview was a joint audio-taped interview, which lasted from thirty minutes to one hour.

Allan (1980) addresses the advantages of a joint interview. He cites that one advantage is the ability to obtain two accounts rather than one. He maintains that the depth of the accounts is also richer. He identifies that the interaction of the couple provides the researcher with material less likely to be obtained when conducting individual interviews. He suggests that during joint interviews one partner often corroborates an account, or supplements it to make more rich. It also allows the researcher to observe the couple together providing information about their spousal behavior not readily obtainable in separate interviews.

Description of the Elements for The Interview

The quest to determine if particular criteria influence one's ability to incorporate the baby into the family has been both time consuming and costly. An ecological model of development, developed by psychologist Uri Bronfenbrenner, influenced developmental psychologist Jay Belsky to conceptualize how parents incorporate their baby into the existing family unit. Belsky proposed that parenting, and incorporating the baby into the family are directly influenced by forces emanating from within the individual parent, within the individual child and from the broader social context in which the parent-child

relationship is embedded (Belsky, 1984). It is equally important to emphasize that characteristics found in these three sources are not isolated, individual entities, but are interrelated and interconnected. This interview covers a variety of aspects in order to uncover these complicated characteristics.

There are eight primary themes with sub components identified in the interview. These themes are described below.

1. Pregnancy History

Pregnancy is a journey. At the end, a woman gives birth not only to a baby, but also to her own identity as a mother. Pregnancy is, therefore, an emotional and psychological as well as a physiological transformation (Peterson, 1991, p. 24).

For many couples, the confirmation of pregnancy is welcome news. For others it is a shock and for some unwelcome news. Peterson suggests that pregnancy is a period of ambivalence and emotional upheaval accompanied by physiological changes. These feelings in the woman give rise to feelings of vulnerability which may manifest themselves by increased dependency on her partner and others (Peterson, 1991).

Age and Timing

In one body of research Daniels and Weingarten explore the timing of one's first baby. Age of the parents is embedded in the timing of the arrival of their first baby. Some of their findings revealed that planning, rather than a particular age, impacted more on a couple's ability to sustain the stresses of incorporating a first baby into their lives. They caution that planning does not necessarily guarantee that the end result will be congruent with their plan or aspirations, but rather, that planning affords one with some sense of control which fosters one's ability to "deal with what is dealt" (Daniels, 1980, p.38).

Russell concurs with Daniels and Weingarten. In her study of women ranging in age from sixteen to thirty-nine she found that age was unrelated to the degree of

stress or crisis that the women experienced, but rather, planning reduced the degree of crisis (Russell, 1974).

The Role of Technology

Pregnancy has become a medical event. High technology scrutinizes the pregnancy process.

While she and her doctor may accept in principle the current popular idea that pregnancy is a normal and healthy condition, the many tests, the careful watching, the constant screening will help her think of her own particular pregnancy as being precarious, even dangerous (Rothman, 1991, p.131).

Terminated pregnancy

Women who have experienced a miscarriage are categorized as high risk. They are often anxious during the subsequent pregnancy even though the present pregnancy may be progressing well. Women who have had an abortion in the past often worry and become anxious throughout the existing pregnancy. Some are superstitious, and some guilt ridden, fearing some form of reprisal during this pregnancy. This creates additional stress on the pregnancy.

It is valid to explore some of these issues with the expectant couple. In the pregnancy history portion individuals responded to questions about how the pregnancy had been for them. Prospective fathers, based on the research review, are rarely asked to share their affective experience related to the pregnancy, but are a central part of this interview process.

2 Family History

**"A people without history is like wind on the Buffalo grass."
Sioux saying (Tillett, 1976)**

Genogram

The idea of employing a genogram when asking participants about their

family history seemed a natural beginning. In the course of conducting pre-admission assessment interviews with children and families the use of a genogram is a standard tool with an established history of validity employed by social workers.

"Families repeat themselves. What happens in one generation will often repeat itself in the next" (McGoldrick, 1985, p. 5). The genogram displays patterns of functioning, relationships and structure continuing or alternating from one generation to the next. It diagrammatically displays stress points from a generational perspective as well as displaying current stresses on the family as it moves through time (McGoldrick, 1985).

"A genogram is a format for drawing a family tree that records information about family members and their relationships over at least three generations" (McGoldrick, 1985, p.1). It can be thought of as a family map with tangible and graphic representations of a family. It is most often utilized by clinicians as a means to map the family structure clearly. In addition it affords the clinician the ability to note and update the family picture as it emerges. It is a way to quickly grasp a large amount of information about a family, keeping in mind family members, patterns and events that may have recurring significance when attempting to understand how a family functions. "Information on a genogram is best understood from a systemic perspective" (McGoldrick, 1985, p. 2). McGoldrick stresses that a genogram is not a quantitative instrument, but rather a subjective interpretive tool with which the clinician can generate tentative hypotheses for further systemic evaluation.

Scanning the breadth of the current family context allows the clinician to assess the connectedness of the immediate players in the family drama to each other, as well as to the broader system, and to evaluate the family's strengths and vulnerabilities in relation to the overall situation (McGoldrick, 1985, p. 3).

McGoldrick (1995) stresses that it maps out the basic biological and legal structure of the family and informs the clinician about what is known and, equally as important, what is not known. A genogram consists of three types of family information: 1. General information : family dates of births, marriages, moves, illnesses and deaths. 2. Primary characteristics and level of functioning of family members: education, occupation, psychological and physical health, outstanding attributes, talents, successes and failures. 3. Relationship patterns in the family: closeness, conflict or cutoff (McGoldrick, 1995, p. 36).

Genograms can help family members see themselves in a new way. "Genograms 'let the calendar speak' by suggesting possible connections between family events" (McGoldrick, 1985, p. 3). With its use the couple can be assisted in planning, strategizing and developing new insights as they ready themselves for their own family drama. McGoldrick stresses that the family is the primary and most powerful system to which a person belongs. She emphasizes that the family consists of the entire kinship network both currently and historically.

The physical, social and emotional functioning of family members is profoundly interdependent, with changes in one part of the system reverberating in other parts of the system (McGoldrick, 1985, p. 5).

The genogram as a part of the interview will assist in identifying strengths and vulnerabilities of the individuals as they make the transition into the role of parenting. The ability to map graphically a two or three generational family unit is a tool that can assist the couple in identifying possible pre-existing support resources within that family structure. It will potentially highlight areas of tension and support that may exist within the family unit of one partner and between the family units of both partners.

Past Experiences

We have seen that the very characteristic found to be predictive of individual differences in parenting, namely psychological adjustment and quality of close relationships have their origins in experiences within the family during childhood (Vondra, 1993, p. 22).

Parental capacity does not develop in the abstract. It develops out of our actual experiences and is filtered through all the relationships of our lives. Individuals bring their own "baggage" to the parenting arena (Daniels, 1980). The couple must make room for the new being in the inner world of their psyche with its array of expectations, images and ideals of parenthood. Residues of having once been a child in particular families at particular moments in time guides one's own capacity to parent (Daniels, 1980). Internal representations related to primary attachment figures during one's growing up may serve as blueprints for other close relationships.

What was experienced in the family of origin shapes what an individual expects from other close relationships (Vondra, 1993, p.13).

Function of the Family of Origin

Vondra and Belsky's research suggest that there is a relationship between patterns of functioning in one's family of origin and patterns of functioning in adulthood. These patterns indicate a continuity of experience from childhood to adulthood. Psychological health and quality of relationships in maturity appear to be connected to those on-going experiences and will impact on the parent-infant relationship (Vondra, 1993). Block emphasizes that it is difficult to trace the connecting thread linking a woman's experience of being mothered and her present mothering role, but the path joining past to present is circuitous with differences between generations more prominent than similar (Block, 1990).

In an earlier body of research Belsky stresses the connection between an individual's parental functioning and past experiences of being parented. To

support this premise he identifies the child abuse literature as one source of evidence which demonstrates how maltreatment from one generation extends to the next. He identifies early separation of a child from one's parent as a risk factor for affective disturbance as well as related difficulties in parenting behaviors. Lastly he identifies the research on fathering that reveals that both high and low levels of paternal involvement predict high levels of involvement in the new father's own parenting behavior. He concludes that, "developmental history shapes personality and psychological well-being, which in turn influences parental functioning" (Belsky, 1984, p.86).

Luis Zayas, who reviewed the limited body of literature on expectant fathers, has attempted to bring meaning to his findings. He describes a disruption in the expectant father's relationship with his pregnant partner resulting from feelings of male dependency revived by his own experiences of being a son, parented, with memories of a maternal attachment interrupted by either the birth of a sibling and / or his mother's attention diverted to his Oedipal rival, the father (Zayas, 1987). Feelings of jealousy commonly arise during the pregnancy.

One father remarked, The attention is on how she is feeling. The focus is away from me. I don't mind the focus being away from me; it's just, there's nothing really to fill the gap. I just ask for a little attention. It's not always positive when you feel like the second seat. I wouldn't mind being a little bit more of the center of attention now and again (Fraktman, 1992).

Once the pregnancy is confirmed expectant fathers begin to experience changes within themselves. Data suggests that these changes occur as a developmental process, with a progression through phases. Men have identified changes in their ability to focus and prioritize. One expectant father (Fraktman, 1992) spoke of prioritizing and being more settled.

Things were very important to me with a career or in my personal life when I was single or even dating. Now things have taken priority over that; being established and setting your own roots down. The priority of family over work. The priority of not wanting to put in as many hours at work or individual type things (Fraktman, 1992).

Some men described a gradual maturational process that began with marriage, resurfaced with home ownership and again with the anticipated arrival of a baby.

Things like commitment to my job became much more important to me. Now that we are going to have a baby I guess in a way it's kind of made me a little older very quickly. I feel a stronger commitment, a stronger sense of responsibility. It's a little scary. I've become a little more tense here and there (Fraktman, 1992).

One expectant father from a previous study that I conducted (Fraktman, 1992) identified his partner's pregnancy as the catalyst for initiating couple's therapy.

Jack Heinowitz, physician, psychologist, family therapist and author eloquently wrote,

Becoming the kind of father I wanted to be has meant looking back, reliving, and analyzing many of my childhood experiences (pleasant and unpleasant); examining the attitudes and values I've learned about being a man, a father, and a partner; unlearning much of what I've been taught and practicing the lessons I do value; continually redefining my sense of purpose and my ideas about masculinity and relationships; and saying good-bye to my old relationship with my parents while simultaneously establishing a new, more equal "parent -to- parent" relationship with them as well as with my wife (Heinowitz, 1990, p.3).

Zayas suggests that the manner in which the expectant father can adjust to the disruption is dependent on his capacity to loosen the "old" attachments.

Worthiness / Self-esteem

Experiences of one's own parenting may indirectly impact on current parenting practices through their effect upon one's emotional disposition. Research has identified an association between adult depression and reports of parental rejection during one's childhood. One conclusion that may be drawn from this finding is that rejecting or uninvolved parents convey to a child his/her sense of unworthiness. This can lead to low self-esteem and a perception of helplessness in coping with everyday life events (Simons, 1993, p. 94). Mercer suggests that some mothering behaviors are learned as the woman is mothered as a child (Mercer, 1985).

It appears that a mother who remembers well how she felt when something bad had happened to her and how her parents responded or should have responded to comfort her, will listen empathically to her own infant's distress signals. In contrast, the mother who can not remember her own childhood distress or distorts her memories seems less able to listen openly and feel sympathetic with her infant (Vondra, 1993, p.16).

The recent and often exhausting experience of labor and delivery followed by the care and responsibility for a newborn often stirs up feelings and memories of dependency, vulnerability and helplessness. Block suggests that it is this experience that a new mother will bring to her experience of mothering.

The experience of caring for a baby stirs up early memories and sensations for all and reminds each woman that she was once as helpless and dependent as her baby is now (Block, 1990, p. 21).

Block further suggests that often the new baby serves the function of "healing" old wounds, and magically transforming past strained familial relationships (Block, 1990).

Giving birth may lead a woman to revise her relationship with her own mother.

For a mother to respond to her infant's complete dependence on her, she must re-experience and work through the longings she once had for her own mother (Swigart, 1991, p.78).

Swigart suggests that the nurturance a mother provides her infant replaces the

longing for her mother as she vicariously feels nurtured and gratified in the relationship she develops with her infant (Swigart, 1991). Block proposes that all phases of a woman's development continue to exist and clamor to be heard as the new mother attempts to discover who her baby is and who she is as she assumes the role of mother while continuing to be her mother's daughter and a woman. Block comments:

The ghosts of childhood experiences disguise themselves in contemporary dress, so that it is sometimes difficult for the new mother to distinguish clearly all the different but familiar voices that echo within her. Often she confuses her voice with the voice of her mother, and the memory she has of herself as a baby blends into her experience of her own baby (Block, 1990, p.8).

Prospective fathers revisit their experiences with their own fathers. This revisiting process appears to directly influence their conception of what they aspire to be as fathers. One expectant father stated,

I envision myself being my father, what my father was to me. This strong man who was very confident. I'm putting myself in his shoes, so to speak, I'm trying to create a role for myself (Fraktman, 1992).

Expectant fathers description of a "good father" included, "someone you can count on; good role model; one who has strong relationships in their family, with their wife; he's a person, allowed to be a person" (Fraktman, 1992). These comments are suggestive of the expectant fathers' personal perspective, which is based on their experiences with their fathers and possibly the "loosening " of old attachments.

In the process of reflecting on their own parents and their parenting styles new parents develop a new sense of closeness between the generations as they each re-live the previous cycle of parenthood and childhood (Plutzik, 1983). Many women report that a deeper bond develops with their mothers as they themselves become mothers, while other mothers admit to consciously approaching mothering quite differently from their mothers. Block suggests that

this process is accompanied by some struggle and most often there is a blending of the positive and negative influences (Block, 1990).

A sample of six expectant fathers (Fraktman, 1992) identified shifts in their family relationships. One expectant father spoke of resolving father-related issues at the time of his engagement. Since the announcement of his wife's pregnancy he admitted that thoughts about his father have undergone additional changes.

I realize that my father is just a person that in fact had some concerns I had. He went through some tough times and some insecurities. He tried the best he could to do what he could, to be a father. Just realizing that this person, this father, is a man, a person, that you can deal with him on a very equal basis now. (Fraktman, 1992)

Another participant spoke of how the pregnancy had changed his status within his own family. He described the change as a "move up in generations; less identified as the 'kids' and more as equals now" (Fraktman, 1992).

Cowan and Coie, who led a support group for first-time parents, identified childrearing as the most explicit and consciously three generational topic for each participant in their group. "Inevitably, early discussions of how they would function as parents led to reminiscences of growing up with their own families" (Cowan, 1978, p. 317).

Questions related to one's family history appeared to be an important component to include in the interview. Listening to the family history provides both insight into what the couple may bring to their experience as potential parents as well as begin a dialogue regarding the possible ways family members may be available to provide post partum support.

3 Family / Cultural Rituals

Some believe rituals are a function that brings balance and connection within ourselves, which in turn leads to creating stability. Rituals are often

employed during transitional periods to assist in quelling inner chaos which is created by entering new and unfamiliar arenas of life experiences. A sense of order is maintained both internally (self) and externally (environmental) (Murphy, 1991). Rituals can be viewed as serving as an anchor, providing a significant connection with life experiences. "Rituals are a means of establishing roots and bonds in life with one's self and others" (Moustakas, 1981, p. 23). Rituals, therefore, can be viewed as practices that enhance growth by facilitating structure, and providing a sense of stability and safety in life transitions. Examples of some life transitions include birth, death, and marriage.

Death and marriage are highly ritualized in the United States. However, birth, and in particular, post partum recovery, are not. As previously discussed, Stern and Kruckman found ritualized practices in other cultures that focused on maintaining balance, which provided a sense of order to promote healing and strengthen the new mother who is temporarily rendered vulnerable during this transition (Stern and Kruckman, 1983).

As a visiting nurse practitioner I have had the opportunity to discuss the rituals associated with the post partum period with non-American families. One Vietnamese woman explained that she is encouraged to eat and drink a diet of warm foods in the immediate post partum period in order to soothe the system which promotes healing. Cold foods, especially ice, and sour foods are discouraged. A diet consisting of hot (spicy) foods is encouraged in order to "cleanse" the woman's system. A confinement period of one hundred days or three months and ten days would be enforced if she were living in her homeland. A new mother, originally from Brazil, described a similar diet of warm foods. A confinement period of forty days would be enforced. In contrast, in this country, a new mother is expected on either week one or week two post partum to bring her baby to the clinic for a pediatric check-up. She, on the other hand

will not be "seen" by her physician until six weeks post partum.

The theoretical formulation of rituals developed by Arnold van Gennep, a French anthropologist, is yet another way to understand rituals and their functions within a society. As early as 1905, during his field studies, van Gennep began to see themes emerging from the various rituals that he observed . His formulations of those observations continue to have relevance in "modern society". He noted that in "modern societies" i.e. industrial societies found in Western Europe and the United States, the practice of rituals, related to some life events appeared to have been abandoned (van Gennep, 1960, p.1). He attributed this phenomenon to the movement of societies from primitive, which employs practices embedded in a high degree of magic and superstition to civilized societies, that utilizes the sacred or religious practices. He became keenly aware that in semi civilized societies life passages were accompanied by ceremonies with the apparent purpose of assisting or enabling the individual to pass from one defined position to another. He further postulated that these rites or rituals were employed during those intervals throughout one's life passage, where regeneration of energy was necessary. These observations led him to classify the rituals or rites of passage into phases which he termed separation, transition and incorporation. He stressed that not all ceremonies contained the three phases (Van Gennep, 1960).

His observations of practices related to birth and post partum convinced him that a mother's transitional period continues beyond the moment of delivery. Among different cultural groups he noticed that a time specific period was allotted to that transitional period. His observation of a Native American Hopi woman's post partum period revealed that it followed a sequence of, first, separation, followed by a transitional period with gradual removal of barriers to finally, reintegration into ordinary life. For the Hopi, this time period was twenty

days (van Gennep, 1960). Van Gennep's belief was that the primary consideration for these rituals was not the physiological recovery of the woman from childbirth, but rather, her social return from childbirth. He noted that a woman's social return from childbirth in 1905 "modern society" tended to coincide with her physiological recovery. In the technocratic civilized society of the 1990's very few remnants of post partum rituals are discernible.

In light of the current research focusing on the rise of post partum depression it appeared important to inquire about cultural/ritual practices for this study.

4. Play: Its Influence on Parenting

"In our play we reveal what kind of people we are"

Ovid

Play is an activity that I participated in as a child and, as an adult, I still hold fond memories. As I approached adolescence my sister informed me that I would have to stop playing. In reminiscing I think some of my play activities subsided, such as playing with dolls, while others continued in more acceptable forms, such as team sports, biking or ice skating. My imaginative play became transformed into poetry writing, drawing, painting, and basket weaving.

When I was pregnant with my first child I wrote to a close friend, "Mother Nature has given me two more opportunities to play, first as a mother and, if I'm blessed, the second, as a grandmother." In my role as a mother I fostered, encouraged and joined my children's play. Play became incorporated in my professional career as a psychiatric nurse working with emotionally disturbed children. The absence of dramatic, imaginative and co-operative play among these children was striking. Parents of these children not only lacked the ability to play, they lacked a sense of playfulness. This observation led me to pursue

the idea that one's playing has some influence on one's development and, perhaps, on one's parenting style.

I pursued this idea through an independent study in which I attempted to discover if a relationship between one's own play experiences and one's ability to parent existed. My hypothesis was that if play contributes to one's developmental growth it might influence one's ability to nurture, to provide safety, to assist during times of stress, to contribute in the socialization process, to problem solve, and to encourage individuation (Fraktman, 1992).

I asked the participants in that study if they felt play was a learning tool which had benefited them and enhanced their lives. The adults with non-problematic children had rich play experiences. They felt that their play was supported by their parents. They expressed more clearly that play had contributed to their functioning as adults. Attributes that they identified included learning how to work cooperatively and competitively at different times; learning how to challenge oneself; learning how to build friendships; learning how to be 'grownups'; and learning about winning and losing (Fraktman, 1992).

Wolf assigns play as a rehearsal for complex sequences of behaviors and skills necessary throughout later points in the life span (Smith, 1984).

Chance views play as the medium that allows

the freedom to fail, the permission to explore the impossible and absurd, and allows the child the opportunity to explore the outer limits of his skill, thereby extending those limits (Chance, 1979, p.22).

Philosopher Ludwig Wittgenstein brings yet another perspective to the concept of play and its function. He suggests that one should not look at it in terms of a single trait, but rather to look for overlapping characteristics, traits that run across many kinds of play the way fibers that make up a thread overlap. "The strength of the thread does not reside in the fact that some fiber runs through its whole length, but in the overlapping fibers"(Chance, 1979, p,10).

One might conclude that throughout one's developing years one builds a repertoire of play experiences similar to weaving a tapestry of play experiences. That tapestry is the foundation for divergent thinking, social relationships, language acquisition, development of problem-solving strategies, and intellectual development. It would appear that the richer the tapestry, the better equipped an individual might be when embarking on the new role of parenting and its inherent demands.

Parents serve an important role in fostering their children's play. As Singer underscores, "The adults who foster imagination offer children a sense of security and closeness they remember long into adulthood" (Singer, 1990, p.161).

Carl Rogers believed that a parent must possess three psychological conditions in order to provide a creative environment that fosters play. Included are: 1. an openness to experience; that is a willingness to entertain another perspective or point of view. 2. an internal locus of evaluation; that is an ability to reflect, criticize oneself and possibly change one's mind. 3. the ability to toy with elements and concepts; that is to imagine, fantasize, create or change one's point of view (Singer, 1990, p.153). One could postulate that for a parent to possess these psychological conditions they should have established a meaningful relationship and woven a tapestry of play experiences of their own to draw upon.

Play is the source of creative experience, new energy, and new feeling and through the play process it is the path to self confidence and self-esteem (Moustakas, 1981, p. 20).

Based on the literature review and my previous research study supporting the benefits of play, I have included questions in the interview which focused on the prospective parent's playing and the attitude and support their

parents demonstrated toward their playing. I asked participants who they played with in an attempt to better understand their capacity to develop and sustain friendships. Inquiry related to participation in team play was an attempt to develop an understanding of one's capacity to compromise, to work together and to develop strategies as a team. This inquiry is directly related to the team work necessary for a couple to incorporate the baby into the family unit. In asking these particular questions I hoped to gain some sense of the individual's capacity to problem solve, to compromise, and to consider another point of view. In addition these questions are useful in assessing one's self-esteem and self- confidence, which can be vulnerable during the transition to parenthood.

5. Ego Development

When two or three determinants of parenting are at risk, it is proposed that parental functioning is most protected when the personal resource subsystem still functions to promote sensitive involvement and least protected when only the subsystem of the child characteristics fulfills this function (Belsky, 1984, p. 91).

Belsky proposes that if something must go wrong personal psychological resources of parents are the strongest indicators of maintaining optimal functioning (Belsky, 1984). He stresses that not only are personal psychological resources seen as contributing to parental functioning, they play an important role in enlisting contextual support (Belsky, 1984). Vondra identifies ego flexibility, interpersonal trust, active coping style and self-efficacy as other broader personality factors that have specifically distinguished the quality of maternal care delivered by middle-class mothers (Vondra, 1993). "An important prognostic indicator of psychological functioning is the quality of close relationships an individual is able to establish" (Vondra, 1993, p.8). Psychological functioning may serve as a link between marital satisfaction and individual adjustment. One might conclude that individuals with a positive

sense of self, an openness to new ideas and experiences, and a belief in one's own ability to make changes may be more likely to create positive relationships and express greater satisfaction with a variety of relationships. This also has implications and supports the literature that individuals with these psychological characteristics access resources to enlist support.

6. The Couple and Their Relationship: Incorporating the Baby

Nearly twenty years ago, Philip and Carolyn Cowan and John and Lynne Coie jointly conducted a longitudinal study of eight couples, who were first-time parents, beginning in the last trimester of their pregnancy and continuing to the first year after the birth of their baby. Cowan and Coie (1978, p.320) identified three primary areas of the couple's relationship that began to undergo alterations as they incorporated their baby into the family: 1. a sense of self, 2. role behavior, and 3. communication patterns. Dissecting the area of the psychological sense of self, the participants identified two aspects that they reflected on and began to change. They identified: what one is or may become and what one wants to be or believes one should be. Discrepancy between the perceived sense of self and the ideal sense of self impacts on one's self-esteem causing it to be in a state of flux (Cowans et al., 1978).

Daniels and Weingarten (1989) stress the need for a reservoir of self-esteem to assist the new parent during this transition. The Cowan study determined that the ideal sense of self responses were a reflection of the individuals' perceptions of themselves in the role of daughter or son. Over time, a shift occurred in which the couples appeared to develop ideals that were more representative of themselves as parents (Cowan, 1978). This finding may have some implications related to psychological strength, self esteem, flexibility and willingness to change roles within family generations.

In 1982, Jerry M. Lewis, M.D. presented his research on "healthy families" at a conference. His research entailed interviewing families with non-problematic adolescents. He developed a list of repetitive criteria that surfaced from the interviews with those families. This work laid the foundation for his more recent research which explored how first-time parents incorporate the new baby into the existing family unit. The couples who appeared to transition more smoothly into the parenting role possessed similar attributes of the well functioning families from Lewis' previous research.

Marital Competence

Lewis and his colleagues have found that marital competence rather than marital satisfaction is a stronger predictor of a couple's ability to incorporate the baby into their family.

Lewis notes,

It appears from the data that it is the level of marital competence at a particular time that is important rather than whether the level of marital competence has remained the same, regressed or improved (Lewis, 1988, p.419).

A highly competent couple, according to Lewis, possesses high levels of autonomy and flexibility, with a strong commitment to the relationship. Within their role as a couple, the individuals equally share power and leadership. Disagreements are resolved through compromise. He suggests that the more psychologically "healthy" the individuals are within the dyad, the more equipped they are to cope with the stress and demands of pregnancy, birth and incorporating the baby into the family. He further stresses that the couple's relationship appears to be even more influential than the individual psychological health in how well the couple will accept the baby into the dyadic system (Lewis, 1988).

Relationship of the Couple

Daniels and Weingarten uncovered four essential themes of a couple's relationship that get played out when a child is born. They identified themes of individuality, nurturance, participation, and intimacy (Daniels, et. al. 1980). Belsky and his colleagues have arrived at similar conclusions. They identified six characteristics that appeared important in facilitating a couple's smooth passage through the transition to parenthood. They include the ability to 1. surrender individual goals and needs in order to work together as a team; 2. resolve differences related to division of labor; 3. handle stresses in a way that do not overstress a partner or the marriage; 4. fight constructively and maintain a pool of common interests despite diverging priorities; 5. realize that the marriage, no matter how good it was before the baby, is forever changed after the baby; 6. maintain the ability to communicate in a way that continues to nurture the marriage (Belsky, 1994, p.16). A critical component of each of these research findings is the reciprocal nature. There is an expected give and take throughout this process with open communication as the conduit. Questions included in my questionnaire attempt to address those particular attributes.

7. Level of Energy

The process of giving birth is labor intensive, especially for women experiencing labor for the first-time. The expenditure of energy is great. Life with a newborn translates into interrupted sleep. Couples experience sleep deprivation during the initial adjustment phase of living with a newborn. By including this in the interview couples could receive anticipatory guidance. In addition exploring this topic provides an opportunity to collaborate with the expectant parents and assist them in developing strategies for getting adequate rest and sleep especially in the first few weeks post partum.

8. Recent Life Changes

In the process of researching various existing assessment tools I found two particular tools which expanded my thinking related to stressors couples may experience in the prenatal and early post partum period. The Social Readjustment Scale is a checklist of forty-two life events that describe common stressful life occurrences that require some degree of coping, adaptation or adjustment (Baird, 1982). This particular tool was developed to study the relationship between specified stress-related life events and one's change in health. The Recent Life Changes Questionnaire is an improved and expanded life events inventory. What drew me to this particular instrument was the reality that life events are categorized as either being in one's control or being out of one's control. Bronfenbrenner's theory of ecological development supports the notion that life events can induce stress and require some degree of adaptation, coping or adjustment. Some examples of recent life events include buying a new home, a recent move, a death in the family, or a recent illness of a family member. Any of these events can induce additional stress on the couple. It, therefore, appeared important to include a question to elicit information related to life stressors, which would be factored into the support protocol.

Chapter IV

Results

Section I

Sample Characteristics

All the couples (100%) attended Childbirth Education Classes. Two participants developed difficulties in the last trimester of their pregnancy. One of the participants developed preterm labor for one week, which was resolved with prescribed bedrest. The other participant developed Pregnancy Induced Hypertension (PIH) the last five weeks of her pregnancy. Complete bedrest was prescribed and adhered to. Frequent visits to the obstetrician were required to monitor her status. All of the women (100%) delivered full term babies. (Full Term ranged from 38-40 weeks gestation) Two women (13%) delivered by surgical intervention, which is usually referred to as a Cesarean Section. For one of the two women, it was determined, after many hours of labor, that the size of the baby was too large to pass safely through her small pelvic opening. The second woman reported that, after 18 hours of labor, it was determined by the physician that her labor was not progressing sufficiently, which resulted in a surgical intervention. (The term not progressing sufficiently usually refers to the cervical dilation process.) Six girls and nine boys were born.

Fourteen (94%) women planned and did have a hospital managed delivery. One woman (6%) planned to deliver her baby at a birthing center, but had an unplanned home delivery instead. Following the birth, which was attended by EMT's who arrived in time to cut the umbilical cord, the participant and her baby were admitted to the hospital, where she remained for two days. It is interesting to note that had she delivered her baby in the birthing center, she would have been discharged 24 hours after delivery per her health insurance policy.

Two women (13%) planned and were assisted in labor by a midwife. All

of the 15 women (100%) expected and did have their partner present to assist them during the labor process and subsequent delivery.

Two women (13%) elected to leave the hospital within 24 hours after delivery. One woman (7%) left before the allotted 96 hours after a Cesarean delivery. Twelve women (80%) remained the allotted 48 hours for a normal vaginal delivery or 96 hours for a Cesarean Section.

Common Themes

Three common themes surfaced during the interviews. The first two, knowledge of parenting and newborn care and breastfeeding, are significant because they help to dispel the myths that caring for one's baby and, in particular, the ability to breastfeed one's baby, are instinctive and become operationalized at the time of delivery. The third common theme, parental leave, is an important one, since so many couples rely on their dual income to maintain a reasonable standard of living.

1. Knowledge of Parenting and Newborn Care

One common theme that emerged for all of the participants was their lack of knowledge of parenting and newborn care. All of the couples (100%) in the prenatal interview readily expressed their lack of knowledge in both parenting and newborn care. Some of the participants reported that they had some exposure to infants and young children, but were quick to explain that their experiences with infants were different. They stressed two factors: Personal interaction they anticipated they would experience with their own baby and the total, all-consuming responsibility they would experience caring for their baby. One expectant mother was quick to maintain that her experience with babies and young children was a separate and different experience. She stated,

It's not the same, I mean basic baby-sitting type thing. Nothing like waking up in the middle of the night and feeding and all those kinds of things.

Six (40%) of the female participants, who were nurses, stressed that their experiences as nurses had little or no bearing on their ability to transition into the parenting role. In addition, they all agreed that their preparation as nurses had little or no bearing on their ability to care for their newborn baby, and especially to breastfeed their newborn. One woman remarked,

Even though I'm a nurse there are plenty of people, some of my friends, who have had more experience with children and infants than I do, so that doesn't make me feel any more prepared having had some training in that area than anybody on the street.

One of the participants, who is a practicing nurse midwife, stated that her clinical expertise was not focused on infant care and therefore she included herself as a novice. She stressed that the advantage that she brought to the experience as a prospective new mother was the knowledge that she would be exhausted and would need help with home maintenance. She stated, "I've always said, people don't need baby nurses, they need someone to help take care of the house."

A. Life with a New Baby

I asked the participants what they thought life would be like with a new baby. All of the participants (100%) had fairly realistic expectations. Although the expectant couples expressed excitement and joyful anticipation about the upcoming arrival of their baby, they openly shared their concerns, anxieties, and visions of what they thought life would be like with a new baby. They attempted to maintain a realistic perspective in the face of ignorance. They worried about their level of fatigue that they would experience. They anticipated disruption, chaos, and hard work and expected a major change in their lives

after the birth of their baby. Their frame of reference was based on exposure to either friends or family members who had become new parents. Comments such as crazy, hectic, scary, and chaotic were commonly expressed. Many spoke of having less time to do things one takes for granted.

One expectant father remarked, "I think there is going to be a big life change. I think we'll have less free time, both as a couple and individually." Others spoke of expecting a major change in lifestyle. One woman spoke of buying a combination baby carrier and backpack that she could use when she and her husband go hiking. "We're looking at ways that we can still keep what we like to do and make the baby go too."

One expectant mother responded by saying, "My guess, unpredictable. Both of us think that the most we know is that we don't know."

One expectant father stated, I think your vision shifts from an internal vision, focused on yourself to something where you're focused and directed toward something outside of yourself. I don't know what to expect. I think just that kind of not knowing what to expect is the scariest part about being a parent.

He wondered and worried about how well he would function being deprived of sleep.

I just imagine being really tired. That's the one thing that I can't really get past right now; thinking about being really tired and how that's going to feel and how I'm going to be able to function when I'm that tired. How we're going to function when we're that tired, together.

He wondered how his relationship with his wife would be affected after the arrival of their baby.

There are so many unknown relationship situations that happen at that time. I don't know. I think we work well together in that type of situation, but I don't know.

Many spoke of assuming a more responsible role.

It is a kind of anxiety about impending change in our life, even though we planned this pregnancy and I'm really excited to be a parent. I feel like we're also taking on a big responsibility.

Similar to the research findings of May (1982). Jordan 1990) and Fraktman (1992), the reality of a growing life struck one father after seeing the picture of the ultrasound.

Just the word 'responsibility' hit me as soon as I saw that picture. Right now she's carrying the baby and I need to support her, but one day I'll be supporting the baby as much and her.

Many spoke of the beginning of a family. One expectant mother said,

I think it's going to add a special closeness between me and the baby and my husband. I'm actually looking forward to having a family and being a family.

Some spoke of personally changing in some way. One expectant father remarked, "I hope my patience changes. That's something I really need, patience."

Another expectant father described an imminent change in his work schedule.

My work during the day is going to stop. I will be taking care of the baby during the day because my wife's job has the health insurance. From that point of view I guess I'll be a kind of a mother in a way, for a time anyway. I work at night so it's not too bad.

Others anticipated life with a new baby as hard work, and anticipated fatigue. One expectant father said,

I think it's going to be like a lot of extremes: very tired, very happy. I'm expecting it to sometimes be trying, worrisome. Just making sure everything's going right.

One expectant mother said,

I get the feeling it's not going to be easy. I think it's going to be hard to get enough sleep. I expect I'll be tired all the time. I think it's going to be great having a baby, I'm really looking forward to that. I'm trying to be realistic. It's not going to be easy. It's a lot of work.

Clearly the narratives convey the mixed emotions that the expectant couples experienced.

One expectant mother described her vision of what she thought life with a baby would be like. She anticipated that life with a baby would be stressful. She quickly stated, "but there's always stress in life." She added, "Fun, challenging, exciting; I'm very nervous." She worried,

Am I going to be able to do this? Am I going to know what to do and how to do it? I know I can always call someone if I don't have the answers, but I just worry.

She calmed herself by saying, "I have a lot of support." She stated that her friends and family were constantly reassuring her with comments like, "You'll know what to do." She responded, "I don't know." She identified family members and friends as part of her informal support network. "I'd call my mom. My grandmother is a nurse. If it was something medical I might call her." She identified her partner as a source of support. She stated, "We'll fumble through it together."

Another expectant mother stated,

I think it will disrupt a little bit of what we have, even though we haven't been together for that long. I think we've both been so anxious to have children all our adult life that we're very much looking forward to it. I think it will make it a busier household and a happier household. I think it's icing on the cake!

Another expectant mother stated, It's going to be a huge change. I'm looking forward to it, but I'm kind of scared.

When I asked her what the 'scared' part was she replied,

Well, I'm scared because I don't know what to do, basically. If they don't tell me what to do I don't know that I'm supposed to do it. I'm just afraid I'm not going to do the right thing. How do you bathe it? How much do you feed it? I've never even changed a diaper. I'm twenty-nine. Pretty scary!

One expectant mother remarked,

I think it will be really busy, but it will be wonderful. It will be tiring and time consuming. I took time off from school so that we will have this time to enjoy the baby. It will be the only time I'll be a first-time mom. I know there will be a lot of stress, too, but I think we'll be able to handle it.

Another expectant mother spoke of the anticipated chaos. She stated,

It's hard to envision it because we see what a lot of our friends who have already had kids, but that's their experience. Everybody responds differently to different situations. I think it is going to be a little hectic because we haven't been parents before.

One expectant father's comments seemed to sum up the varied emotions that the participants were experiencing. When I asked him what he thought life would be like after the baby's arrival, he answered,

I have no idea! I'm very excited about it; I'm looking forward to whatever 'it' happens to be, but I really have no idea. I'm a bad visualizer, very concrete. I have no idea what it's going to be like, but I'm looking forward to the adventure.

2. Breastfeeding

The issue of breastfeeding surfaced as a common concern for many of the expectant mothers. Thirteen women (87%) intended to breastfeed their baby. Many of them expressed anxiety. Four of the thirteen women (30%) had developed a proactive plan of accessing breast feeding support. One woman stated,

I'm worried about breastfeeding, just because I know so many people who have had trouble and have given up. I don't want to do that.

In anticipation of possible problems, she had generated a list of telephone numbers of breastfeeding resources including friends who were experienced in breast feeding. One woman joined a nursing mothers group at her work place. "I've been meeting with them and asking questions about the whole process----getting scared!" Another woman stated that she had talked to someone from La Leche. She also talked with her nurse midwife. She had developed a plan where she could access knowledgeable breast feeding resources if the case required. The fourth woman had been encouraged by her sister to contact La Leche. She located a group in her geographic area and had already attended a couple of meetings. She said,

I've gone to a couple of meetings before having the baby, because that's the most important time, I think. Go and get the information from all these experienced moms with their babies; giving me tips on how to prepare and what to expect. It's a great resource.

One woman expressed her ambivalence about breast feeding.

I'm planning to breast feed because that's what everybody wants me to do. I just don't really want to. I don't know. My physician presented it to me as 'you will breastfeed , won't you?' Everybody, my friends, my parents, his parents say, 'You will breast feed, won't you?' I feel like I have to make an effort to try, but I firmly believe that if I'm not into it it's not going to be worth it, so I'm buying bottles. I will try it just because I think that's what people expect me to do. I continued to explore this issue with her.

She stated,

I never thought it was great to do. I hear women and friends talk about what happens when the baby cries and you're out in public. You're always embarrassed. I plan to go back to work. I want my husband to be able to feed the baby. I may try it and like it, but I'm not thrilled with it.

She then confided. "People think you're a bad mom if you don't breastfeed. That really concerns me."

She said that she was feeling pressured. "I don't want to be a bad mom."

I asked her to describe a bad mom. She replied, " Day Care--I've been called a bad mom already for wanting to put my child in daycare."

I asked, What's a good mom? She answered,

I think a good mom is somebody who really is attentive to her child and the child's needs. I don't think a good mom needs to be there 24 hours a day. I think a mother who is happy is a better mother because she can give that child so much more love and attention than a mother who is not [happy]. I think a good mom is a happy mom.

After a long pause she stated, "A happy mom is someone who is not breastfeeding."

One participant, who expected her mother to come to help after the arrival of her baby expressed her concerns. She stated that she was worried because her mother was not supportive of her breast feeding plans. When I asked her how she knew, she replied,

She didn't breastfeed us. Her experience from hearing from her friends is that it's painful, uncomfortable, a hassle, it enslaves you to the baby in ways that you should not be enslaved, and your husband should be able to do the feedings. I think she doesn't want me to face any of those discomforts and inconveniences. But, there is this other self interest agenda of wanting to be able to take care of the baby.

When she informed her mother that she was planning to breastfeed she said her mother was not very understanding. She said her mother replied,

Well, I totally understand. You should give it two days and if it doesn't work, it doesn't work.' S. stated, I worry a little bit about having someone in my house with me during the first week who is not supportive, because that seems like such a critical time to get established breastfeeding.

She had decided that she really wanted her mother to be 100% supportive. Being more realistic she commented, "It's not subterfusing my efforts, even if she can't be really supportive, she needs to stay quiet."

The thirteen women (87%) who intended to breastfeed did breastfeed their newborn baby. Two women (15%) abandoned this plan. One participant felt unsupported by the pediatrician. She was encouraged to supplement the breastfeedings with formula because the pediatrician felt her baby was not gaining weight fast enough. After two months of, what she described as, struggling with her infant to breastfeed, she reluctantly abandoned breastfeeding.

The other participant elected to bottle feed her son after two months. Due to his constant crying she believed that he continued to be hungry. She said, "I just couldn't keep up." In addition she felt her pediatrician was not supportive. She reported that his response to her concerns related to her crying infant was insensitive and unrealistic. She stated that he advised her, "Just let him cry for fifteen minutes!" It is worth noting that this is the same woman who stated that a happy mom is one who is not breast feeding.

The notion that breastfeeding is an instinctive process is easily dispelled by the narratives of these women. The importance of support, especially in the beginning phase of breastfeeding cannot be overstated.

Two women (13%) bottle fed their baby as planned.

One woman, who had decided not to breast feed because of her present school schedule stated, "I feel guilty that I'm not breastfeeding. Everyone's making me feel really guilty. On top of that I have all these papers due." She said, "Everyone is asking, 'How come you are not breastfeeding?' She said that people made her feel very guilty in spite of the fact that she knew it was the correct and rational decision at that particular time.

3. Parental Leave

The issue of parental leave was pursued in the interview since it

continues to receive public and political interest. Unlike most of other industrial countries in the world, the United States is noticeably slow in its provision for paid parental leave. One micro-step is the Unpaid Parental Leave Bill, which was passed in 1995.

Two (13%) men anticipated paid parental leave, with one receiving two weeks of paid parental leave. The other prospective father reported that his place of employment offered paid parental leave, which was very flexible with an initial two week leave immediately post partum. He stated that if complications arose additional time off would be granted. He added that if he were the primary caretaker within the infant's first year, he could take an additional three months of paid leave. He confided that although this three month benefit was offered, it was understood knowledge that if utilized, it could impact on advancement in the company. To his knowledge, only one employee, (out of about two hundred) had actually taken this leave. In spite of this, he planned on utilizing this benefit when his wife returned to work. The remainder of the expectant fathers (87%) anticipated paid leave, which usually represented vacation time or a combination of accrued vacation and sick time.

Seven women (47%) would receive an unpaid maternity leave. A four or six week unpaid maternity leave is a fairly standard employee benefit. Maternity leave usually insures a position upon one's return to the work place. In addition the employee can continue paying for health insurance at the group rate. The women, like many of the expectant fathers, used their accrued vacation and sick time to insure financial reimbursement for their leave or to extend a paid leave. Five (33%) of the women would receive no maternity leave benefits: two were students; one resigned from her employment and two employed women would receive no benefits. Two women (13%) would receive a partially paid maternity benefit package. One would be paid for the first four weeks and her position as

an educator allowed for three additional months of unpaid leave over the summer. The second woman would receive eighty percent of her salary for four weeks. To extend her leave she planned to use three weeks of vacation and three weeks of unpaid leave. One woman (7%) would receive six weeks of paid disability leave. This woman, who immigrated to the United States from Canada, stated that her government has national health. She stated that she has found it difficult to receive a six week leave in this country when she knows she would be eligible for more if she were living in Canada. There, she would be eligible for a six month paid leave, classified as unemployment compensation, which is less than one's regular salary but the benefits include some compensation plus remaining home with one's baby for a longer period of time.

The ongoing public and political issue of mothers remaining home with their babies or returning to work can be highlighted by the lack of financial provisions that are available to them. One might surmise that the poor financial provisions that this country, the wealthiest in the world, offers its new parents, demonstrates the lack of value that is placed on the work of parenting. It further demonstrates the lack of value it places on its children, the future of our nation.

Section II Description of The Assessment Protocol Findings

The results of these findings are organized to follow the items in the Assessment Protocol. In addition, an evaluation of the protocol is discussed after the findings portion of each item.

1. Pregnancy History

The interview began with a pregnancy history. Attempts to ascertain both areas of strength and areas of stress that might influence the couples' ease of transitioning into the parenting role were explored.

None of the couples (100%) experienced fertility problems. Ten couples (67%) had a planned pregnancy. Five couples (33%) had an unplanned pregnancy. Four women (27%) had experienced a miscarriage prior to this pregnancy. Four women (27%) had an abortion in their earlier years. Three women (20%) underwent amniocentesis during this pregnancy. Three women (20%) and two couples (13%) would present their parents with their first grandchild.

A. Unplanned

Several of the couples minimized the unexpected aspect of the pregnancy stressing that the planfulness of the pregnancy does not lessen the surprise when the news of the conception has been realized. One woman remarked,

On some level, I think, that even when you plan it, it's a shock. To be pregnant and realize that you're going to be responsible for this human being. I think, no matter how much you're prepared for it mentally, it's still going to be a pretty amazing leap.

She paused and then added, "I think probably it would have been a little less of a leap. Yeah, in terms of preparation, just like getting prenatal care right away."

One expectant father said,

No one is really prepared for it. As much as people say they planned on the pregnancy, you don't know what's going to happen from one day to the next.

What is interesting is that several of the women who spoke of the pregnancy as "unplanned" acknowledged that it was not necessarily unplanned. They seemed to talk around the issue, claiming some responsibility for the planned aspect of their unplanned pregnancy. Their partners, on the other hand, expressed shock and surprise. They did not acknowledge or claim responsibility, but, rather, assumed a more accepting position, which was followed by resignation.

One woman remarked, "I don't really know how to describe it because it wasn't planned like we were trying, but we weren't using anything to prevent it."

One woman qualified her unplanned pregnancy as an example of how she and her spouse function as a couple, especially as it relates to their decision making strategies. She stated,

The thing with the baby is very typical of the way, I think, major decisions happen. They don't all happen. I mean, [this pregnancy] it wasn't exactly planned, but it wasn't exactly not planned either. It was something we had certainly talked about and we sort of let slide a little bit. It sort of happened, so we sort of feel like, (he especially), that if it happened then there's a reason that this happened. That's sort of the function of both of us.

I asked her what would be different if the pregnancy was planned. She replied that she would have done her "shopping" for a practitioner before becoming pregnant. Her partner remarked,

It was really a shock to the system. It was completely unexpected. A major life change is imminent. It wasn't a thing that we had any choice about. Getting married, at least, you have a choice; this choice is being made for you so it was pretty scary. We don't know how we're going to work out as parents.

Another woman whose wedding plans were changed to accommodate this pregnancy stated,

Having the baby was probably an accident, but not an accident. From the minute we knew we were pregnant, we were going to have the baby, there was no decision as to have or have not.

This woman regretfully spoke of "letting her parents down" and not upholding their expectations of her as the eldest child. She spoke of taking each day as it comes.

This pregnancy wasn't planned so its kind of a gradual acceptance. I know its going to change our lives, but I like to think that the baby's going to blend into our lives.

Her spouse referred to the pregnancy as a shock and his feelings as "fever pitch"

I asked him what would be different if this pregnancy were planned.

Well, if it were planned I imagine that we would have had a house and the ideal, at least, settled in a good career, settled in somewhere financially. I have a very laissez-faire attitude towards this--it has happened. I've come to accept this and now I'm at a fever pitch.

When I asked one participant about the timing of this pregnancy she quickly remarked,

The most unplanned thing I probably have ever done. Had it been planned it would definitely have not been in my senior year [of college]. If I had a choice, it would definitely not have been in the middle of the second semester of my senior year.

Her partner remarked when asked about the timing, "It was unplanned, very unplanned."

One prospective father talked about the pregnancy as a surprise. He expressed his resignation by taking a positive position.

He stated,

It was a surprise, but it really wasn't anything that we hadn't discussed prior to getting married. It was a surprise, but maybe, time. I want to think it was time, to put a positive spin on it.

B. Planned Pregnancy

A level of anxiety, ambivalence and uncertainty was evident in the couples in spite of the planned aspect of their pregnancy. Many expectant fathers spoke of adjusting to mood changes displayed by their partners. Some spoke of assuming more household tasks in the latter stages of the pregnancy. Others voiced concerns about their future as a couple.

One expectant father spoke of the pregnancy as "exciting and terrifying." He stated that he and his wife "had gone through these phases in tandem." He identified the second trimester as a benchmark for his anxiety.

Toward the tail end of the second trimester the fear set in. Wondering, looking at our friends who are parents, how we're going to fare. Our predominant concern is how it's going to affect our lives together. We have a great marriage and we really enjoy our current lifestyle. We have all kinds of concerns about what it would do to that lifestyle. At the same time, we're really thrilled to be having a child and raising a child together.

Similar to the research findings of Jordan (1990), May (1982) and Fraktman (1992), one expectant father spoke in amazement regarding the fetal development. As a result of seeing changes occur in his wife, her body and the fetus he remarked,

I feel ready to be a father. I think the first few months you're getting used to the idea, or just the thought of 'wow, I'm going to actually be a father.' Now, when I feel like I've gotten used to the idea I still haven't--it still hasn't hit me. I don't think it will hit me until the baby's born.

In contrast, one participant, who did not complete the research project, had already thought about the care of her baby. She remarked,

Oh, it's going to be a big change. I'm ready to take on the responsibility. Unfortunately, I don't think he is. He thinks everything is just going to be normal and I'm going to be able to do what I do now. He's not going to worry about anything. I don't know what he's going to be after the baby is born. We'll have to wait and see.

She worried that she would bear the full responsibility of caring for the baby. When I asked her if she had talked to him about her concerns she stated,

He's not so easy to talk to. I can't really talk to him about it because a lot of times he takes the offensive. I just don't say anything, just let it go and see what happens.

I pursued this further. I asked her if she was aware of these shortcomings before she got pregnant. She replied, "Yes, I was. In a way I'm kind of hoping that when the baby is born, maybe he'll change a little. I could be dreaming, but I wanted a child anyway."

Although this was the beginning of the interview process, concerns about this woman, her marital situation and her lack of support resources had already begun to surface.

C. Gender Knowledge

None of the couples expressed any strong preference for a baby of a particular gender. Six couples (40%) knew the sex of their baby. This information did not appear to have any particular influence on the couple's adjustment to the pregnancy, or their potential need for support.

One expectant father stated, "I was ecstatic when we found out that it was a baby girl." I asked him why.

He answered, Well, this is more like a miracle birth for us. When she had the problem [miscarriage at six months] she was told that she may not ever get pregnant again. If I had a preference, I would love a baby girl, just because she's daddy's little girl. But, healthy comes first. I'd be happy either way.

Three (50%) of the six couples had firmly decided on a name for the baby

while the remaining three continued to discuss possible choices.

D. What's in a Name?

**"A good name is better than precious ointment"
Ecclesiastes 7:1**

Choosing a name for the baby surfaced as an unexpected source of tension for some of the couples.

Child naming serves as a mediating device -- a tool that, at first, marks the child's standing in the social world and subsequently becomes an internalized name for one's own self (Valsiner, 1989, p.171).

Some viewed naming the baby as a way to maintain a family name or to cherish the memory of a deceased family member. It was evident that a good deal of discussion with eventual compromise had occurred for several of the couples.

One expectant father stated,

We've kind of decided on a name. It wouldn't have been my first choice. I would have selected a Gaelic name, a really traditional Irish name, like Connor or Corloch. But, he's going to be born in America so an American name is all right.

One expectant mother confided,

This was a little bit more difficult [choosing a boy's name] because I'm Irish, one hundred percent Irish and my husband is one hundred percent Italian. He didn't want any Irish names and I didn't want any Italian names. So we came up in the middle. Greek names.

Her husband stated that he was happy with the names they had chosen. "If it's a boy it's Nicholas Anthony. Anthony is after my father. My father passed away seven years ago."

One expectant father said if it's a boy it would be named after him.

He said,

If it's a girl her name will be Julia. We picked Julia because that's my paternal aunt. We were very close. It was like a grandmother/grandson; friend/best friend relationship. She just passed on.

The issue of religious practices or family traditions created tension for some couples.

Personal interests of family members, their wishes and their interpretations of cultural rules may lead to negotiations about the naming of a baby (Valsiner, 1989, 171).

One couple described their dilemma. She wanted to name the baby after her sister if she had a girl. Naming a baby after a living person is not customary in the Jewish religion. He said, "It's taboo!" After much discussion they came to an agreement. "It was a compromise for me, and for him too, but a little more for me." She reassured me that a boy's name was already settled upon. Her husband described his perspective of the naming issue.

She's a very strong feminist, but she is not a stickler for keeping her last name. The bottom line is that she agreed to have the baby have my last name. It's the first name that we're having trouble with.

One expectant mother, who knew she would deliver a son, stated that his name is Louis Anthony. She said,

I wanted a French name and Anthony is a mix of English and Italian. Even though my husband is American he has an Italian origin. I think it's important that you give a name that has meaning. Louis means 'great warrior'. I hope it will help him through life. Anthony is 'praiseworthy', you know, like of great value. I thought it was a good combination.

One expectant father, who said that he and his wife had discussed names, expressed his ambiguity. He said, "Something keeps holding me back. You know, it's a name that is going to be for the rest of its life."

A name is a reflection of many things. It is first and foremost an identity--in society, in geography, and in time. A name can also be a lasting link with a family's past, an expression of parental love, and a sort of talisman to invoke a rich and healthy life. (Chatham-Baker, 1991, p.7)

E. Technology

The use of technology during pregnancy helps to portray pregnancy as dangerous requiring careful surveillance. One prenatal test, amniocentesis, (see Appendix) is usually reserved for women over the age of thirty-five. It is invasive, presenting inherent risks to the integrity of the pregnancy. Women undergoing this test often experience varying degrees of stress, both from the actual procedure as well as waiting for the test results.

Three women (20%) had an amniocentesis. Two of the women were over the age of thirty-five. One woman had a amniocentesis secondary to a positive AFP test. (See Appendix)

She and her husband describe their experience.

The AFP test [Alpha-Fetal Protein Test] was abnormal, which it is in an incredible amount of cases. I had to go for an ultrasound and amniocentesis. That was a nightmare. Everything was fine. I think it's really irresponsible that they do the test (AFP), but that's another story entirely.

Her husband remarked,

In the early stages there was some question that we were going to have a Down's child; that was very hard. Going through the series of tests, the amniocentesis, that was very hard.

F. Abortion

Four (27%) of the women had at least one Therapeutic Abortion (TAB), in their earlier years. One of the women spoke of retribution for having had an abortion in her earlier years. She brought it up in the context of waiting until her fourth month before making a commitment to choosing a practitioner who would

follow her through this unplanned pregnancy.

I think it would have been better for me if I had gotten care right from the beginning. Maybe psychologically there was a part of me that didn't want to buy any books or do anything until the fourth month anyway. Partly because I was dealing with the idea of having a baby and also I was a little superstitious about having a miscarriage or something--- cause I've had an abortion before and I heard it's likely that you'd have a miscarriage the first time you get pregnant after that.

G. Miscarriage

Four (27%) of the women had one miscarriage prior to this pregnancy.

One of these women had an abortion in her younger years. Some of the women experienced high levels of anxiety during their present pregnancy, which was directly related to the miscarriage.

One woman spoke of the miscarriage as "very traumatizing". She recounted her excitement over the first pregnancy. She and her husband wanted to have a baby. They had been trying for about one month. "That was the focal thing in my life. The day I found out I was pregnant I told everybody."

She described the event leading up to the miscarriage. She was eleven weeks pregnant. She had gone in for a scheduled ultrasound.

I was by myself. They told me the baby had stopped growing at six and a half weeks. It was the worst experience of my life. The second time I got pregnant I was upset because I was so scared the same thing was going to happen. I was scared that I would to have to go through that again. I don't care how many weeks pregnant you are it's still a part of you. Now I'm okay, but I still get paranoid. I have to make sure it's moving. I'm eight months and I still ask, 'Is everything okay?' So until it actually comes out I think I won't be satisfied until I actually see it.

In contrast another woman spoke of the disappointment she experienced after her miscarriage. She stated that she had done some reading which helped inform her about the chances of a miscarriage in a subsequent pregnancy. In spite of her disappointment, she stated that she felt supported by her

obstetrician and her husband.

Another woman spoke of her miscarriage in similar terms. She stated that when she found out she was pregnant she was initially nervous because she had had a miscarriage one year before. She stated that because this pregnancy had gone so well that she didn't feel that nervous anymore. "You know, one in ten. It happens. I just think it happens now and then. It was traumatic; it was hard. In retrospect it's fine."

Her husband described their reaction to the present pregnancy a little differently. He spoke of the terror. He admitted that he wasn't as terrified as his wife. He stated that hearing about other women who had miscarriages and then had successful pregnancies helped decrease his level of anxiety. He stated that his wife was more nervous than he was, especially in the first few weeks of the pregnancy.

One woman spoke of how her miscarriage at six months into the pregnancy had impacted on her present pregnancy.

I think it terrified me for the first couple of months. Six months was the deadline. If I made it to six months every day after that was like a gift. It was scary. My poor partner has been watching every move I make.

During one of the routine scheduled visits the fetal heart rate dropped.

"Once the heart beat dropped. We went for an ultrasound and everything looked fine. No matter how much they reassured me, I didn't know."

She spoke of the doctor's reassurance as hollow. She said that they said everything was fine the last time. She stated that while they say everything is fine they want to do ultrasounds every month. She spoke of this pregnancy as her last shot.

This is my last shot. I wasn't going to try again. If this pregnancy didn't work out, I thought, 'I can't go through it again.' I was panicked. Every day after her heart beat dropped I found myself calling my doctor about every little thing.

Her partner had been affected by her experience. When I asked him how the pregnancy had been for him he replied,

Very emotional. She lost a baby a few years back in the sixth month. Anything over the sixth month was like pins and needles. It's been very stressful, not knowing what's going to happen, just waiting for each month to go by.

He added that he has experienced "sympathy pains" with the pregnancy. I asked him to explain. "Frequent urination, tiredness, a little of the scatter brain." He stated that these symptoms began at the end of the second trimester. He reported that most of these symptoms have since subsided, with the exception of the fatigue, which he stated could be work related. It is worth noting that the end of the second trimester coincides with the end of the sixth month of pregnancy which is a date that both of these individuals were focused on.

Evaluating the Pregnancy Element in the Assessment Protocol

The concept of including pregnancy questions in the assessment protocol proved to have importance. All of the participants were clear that they were venturing into unfamiliar territory. For those couples who had experienced a miscarriage there was heightened anxiety. The merit of including such question is demonstrated by the participant who did not complete this research project. As she responded to questions regarding her pregnancy, issues regarding her, her marital relationship, and her lack of post partum support began to surface early into the interview. Her responses raised concerns for the interviewer. Her case is a good example of how quickly this Assessment Protocol can detect areas of vulnerability that indicate the need for social support.

II. Family History

Employing a genogram to gather one's family history proved to be both efficient and expedient. As Monica McGoldrick (1985) suggests there are

additional benefits. As the family history is being diagrammed, family issues, tensions and significant occurrences begin to emerge. Insight into the family dynamics can be gained. It helped to clarify where the couple might comfortably solicit support. Often relational issues surfaced in the context of the family history.

List of Participants

A list of the fifteen couples with fictitious names are included to help orient the reader.

Anita and Barry have been in the relationship for eight years and married for five and one half years. This is a planned pregnancy.

Barbara and Bruce have been in the relationship for eight years and married for six years. This is a planned pregnancy.

Bernice and Jack have been in the relationship for five years and married for two years. This is a planned pregnancy.

Carla and James have been in the relationship for two years. They are unmarried. This is an unplanned pregnancy.

Christine and Greg have been in the relationship for one year. They are unmarried. This is an unplanned pregnancy.

Eileen and Chris have been in the relationship for six years and married for one and one half years. This is a planned pregnancy.

Heather and Phil have been in the relationship for two years and married for one year. This is a planned pregnancy.

Maureen and Frank have been in the relationship for five years and married for three. This is a planned pregnancy

Laurie and Mark have been in the relationship for five and one half years and married for three years. This is a planned pregnancy. Laurie emigrated from Canada

Leah and Doug have been in the relationship for two years and married for about four months. This is an unplanned pregnancy.

Linda and Ben have been in the relationship for five years and married for two years. This is a planned pregnancy.

Monica and Gerald have been in the relationship for three years. They have been married three months. This was an unplanned pregnancy. Monica came from Ireland.

Sally and Jim have been in the relationship for five years and married for one year. This is an unplanned pregnancy.

Sonia and Dick have been in the relationship for two and one half years and married for one and one half years. This is a planned pregnancy.

Sylvia and Don have been in the relationship for six years and married for four years. This is a planned pregnancy.

Esther has been in the relationship for nine years and married for seven years. This is a planned pregnancy. She did not complete the study.

Genogram Examples

In order to develop a clearer understanding of a genogram and its function two examples will follow. Diagrammed genograms are presented after each example. Examples #1 and #2 illustrate the dramatic range of information that is possible to diagram on a genogram. It further demonstrates how the lack of information an individual shares can be as revealing as the abundance of information divulged.

Example #1 **Mark** (Mark is married to Laurie)

Mark is a 43-year-old expectant father who appeared reluctant to meet with me. His answers were curt and unwelcoming. His affect was predominantly flat. When I attempted to draw the genogram he needed a great deal of prompting. He reported that his grandparents were deceased. His parents were alive and he has an older sister, who he stated, "never had much of a relationship with". Because of his resistance to participate in diagramming the genogram, I began asking him about his play experiences. I asked him if his parents were supportive of his play. He responded,

I don't really remember much about them. They left when I was very young. I couldn't tell you what their guidance style was. I couldn't tell you what encouragement they gave me. Everything I did with myself, I did by myself. I was on my own at fourteen. I raised myself since I've been fourteen

I asked him if he lived with another family. He replied, "No, it was with a friend."

As the interview continued Mark shared some of his business misfortunes and disappointments related to his professional experiences that have left him bitter, and have impacted on his motivation and even his willingness to dream. He remarked,

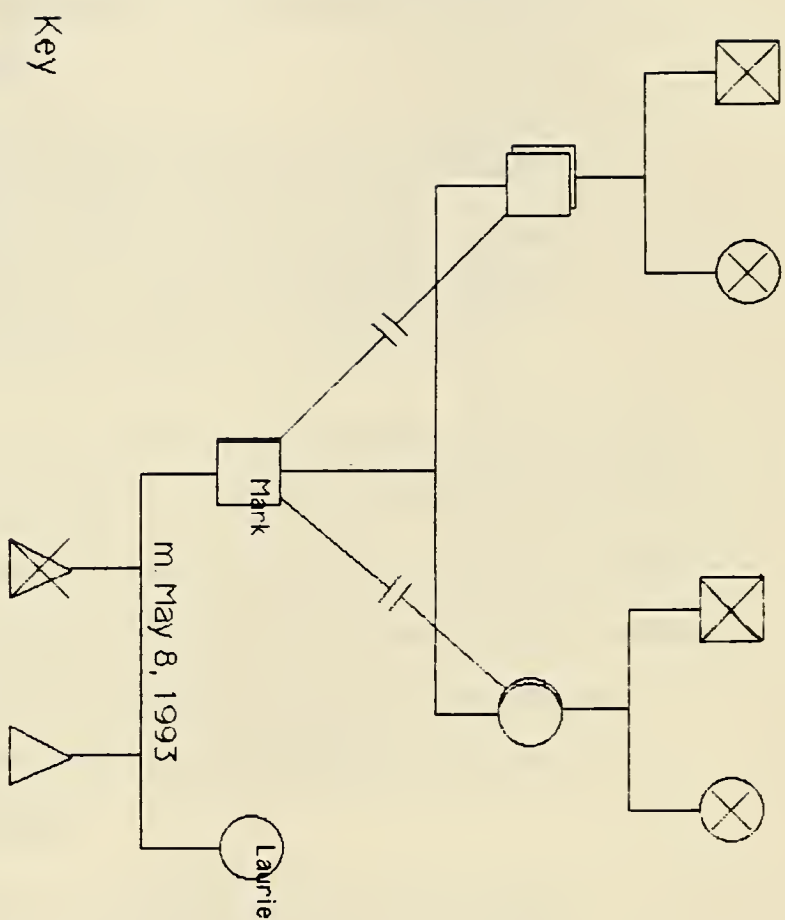
I'm not ambitious about anything. I really don't have the energy. I could care less about anything in the outside world. Doesn't affect me; I'm not interested. My family does, my castle, my kid.

This was one of the most uncomfortable interviews I have ever conducted. It raised many concerns about how the stress of pregnancy and the post partum period might impact on the transition into the parenting role for Mark and Laurie. I asked him what ideas he had related to post partum support. He responded, "I have no idea." He described himself as someone who needs a fair amount of rope to try things 'yourself' before somebody comes in and rescues you. He said,

How much rescue? The only rescue I need is if there's a health problem. I don't need anybody to tell me. I figure parents have been raising kids for a couple of thousand years. They all figured out what to do with them. I'll just figure it out on my own, as it goes.

I worried about Mark's responses. He appeared depressed and insulated from any feelings of inadequacy. He appeared closed off, in spite of the fact that his partner described him as one who enjoyed socializing with friends on the weekend and especially showing off his culinary skill. From his remarks, "I'll just figure it out on my own, as it goes." I worried that he would not solicit help.

MARK



Example #2 Esther

Esther did not complete the research project. She, however, is important to include to demonstrate how the genogram quickly informs the interviewer of familial tensions and where available informal support may be elicited.

Esther began by telling me about her paternal grandparents. "I have my grandmother and my step-grandfather, who I don't particularly care for."

I asked her to elaborate.

He reminds me of a scrooge, number one. He has a very poor attitude about a lot of different things. I don't think he cares for kids very much, either. There are a lot of grandchildren and great grandchildren. He complains they are too noisy and too much money is being spent on gifts which he's not wanting to do. He's always complaining. He's a phony. He tries to act like he loves you, but he really doesn't.

She spoke about her father who had recently undergone surgery for recurrent cancer. She described him as being angry and depressed about the necessity of a colostomy. She described her mother as "constantly stressed out. She does too much for everybody in that house." She stated that her mother had a mastectomy for breast cancer in 1989 and in October, 1995, she was surgically treated for ovarian cancer. She remarked that her mother has appeared to bounce back quickly.

I think what pushed her to bounce back so quickly is the fact that she has my father to take care of, my brother, who still lives at home, and my nephew. My sister had a child when she was eighteen. Due to the fact it was a boy, she didn't want anything to do with him, or with us as a family. She's kind of out in left field some place.

When I began to explore the possible support resources available to her she stated,

I wish my parents were a little more helpful with me than they are right now. As much as my mother says she stands by me, her world is too involved. She then confided, My mother is telling me the only way she'd help me is if somebody brings me down there [to her house]. She will not come up here [to my house]. We've invited them several times, they just don't come.

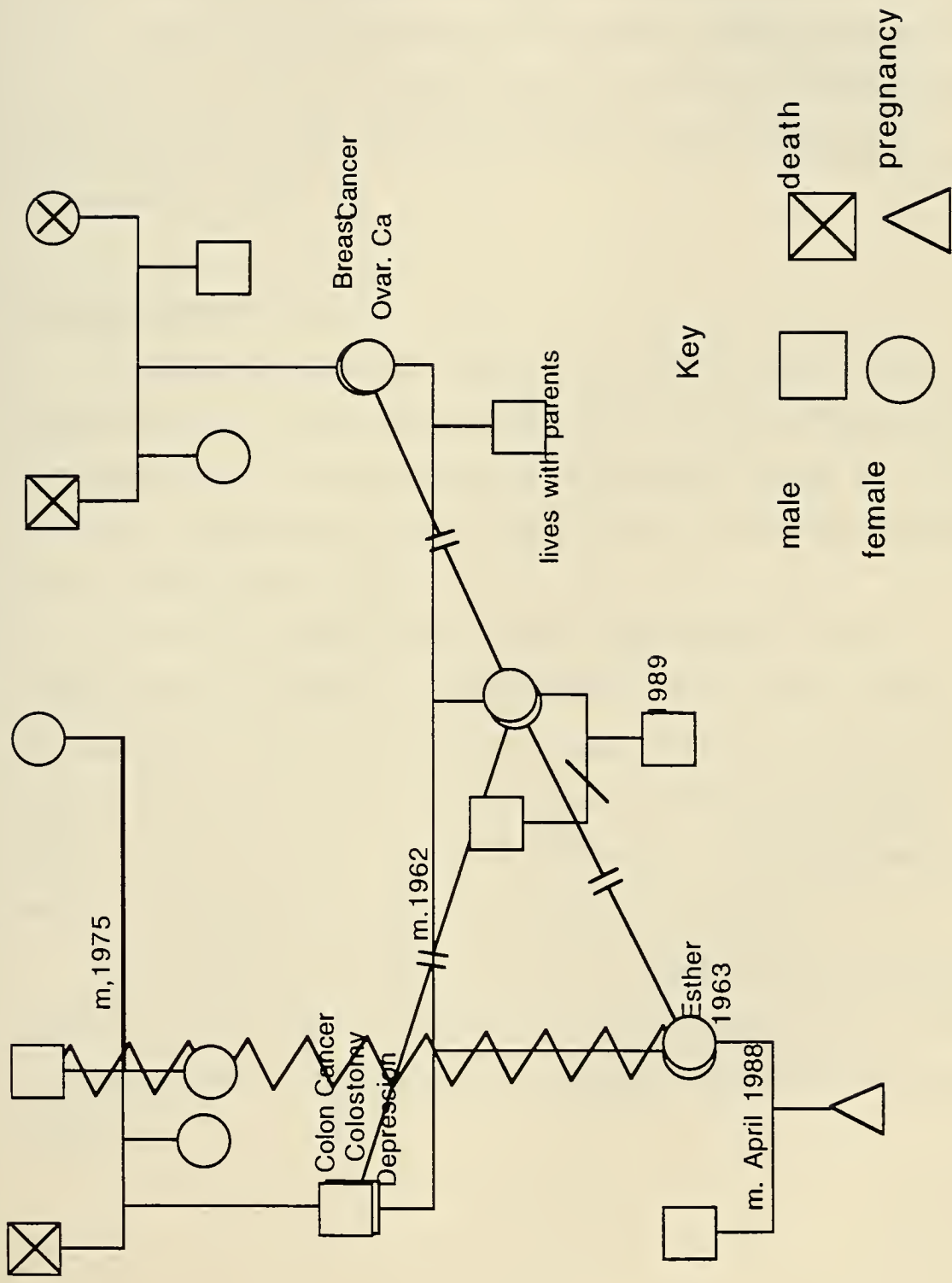
I asked her what her understanding of this was. She reported that she didn't know. I asked if they liked her partner. She replied, "They don't like him. That's because of all the things he's done to me." She acknowledged that in the past he had been physically abusive. She reassured me that he has not been abusive for some time now, as a direct result of their going to couples therapy. I asked her if her partner liked her parents. She answered, "I don't think he cares for them very much."

I then inquired about his family for possible support resources. She identified her partner's sister as the most reliable source of support. She then reverted back to her original position.

If nobody is there to try and help me it's going to cause a problem. It's going to make it very hard on me. No matter what, whether I do it on my own or whether I do it with somebody. I've been doing a lot of things on my own even before I was pregnant. It wouldn't make any difference. This is just one of the things that I've already accepted. I have to figure that I'm going to be 90% taking care of this baby. We'll just wait and see.

The responses that contribute to mapping out this genogram quickly alert the interviewer to intergenerational tension, interfamilial tension and marital tension. The readily available visual history allows the interviewer to explore support resources.

Esther



Evaluating the Family History Element in the Assessment Protocol

Gathering a family history proved to be effective in two ways. First it helped to develop an understanding of the couple from the perspective of their family of origin and secondly it began to identify what sources of support within the family system were available. These few examples demonstrate the importance of utilizing a genogram as part of an assessment interview. Very quickly complex information can be obtained related to a family system and how it functions. It can serve as a reference point when attempting to understand an individual's behavior or thought processes related to the pregnancy and available social support.

III Family / Cultural Rituals

Questions were included in the interview regarding family or cultural practices related to the birth of the baby and care of the mother in the immediate post partum period. The fact that responses in this section revealed little or no knowledge of ritual practices it may not be worthwhile to include this element in future studies using this protocol

Eleven of the couples (73%) expressed no knowledge of rituals or cultural practices that related to post partum care. They expressed very little, if any, importance of rituals. Some stated that they would have the baby either baptized or christened. They, however, envisioned this happening several months after the baby's birth. They viewed this event to include a gathering of friends and relatives who would usually bring gifts for the baby.

One woman, who described herself and her husband as non-practicing Catholics, were planning a naming ceremony to be celebrated several months after the baby's birth. She confided that this celebration was still in the planning stages.

I know I want there to be singing and people bringing their own words into the ceremony, what they would wish for the baby. It will be outdoors, probably in the middle of the summer.

One participant described the tradition that her family practices.

"We make a quilt. Everybody makes a square, and embroiders a square into the quilt." She explained that each family member, including the kids, designs a quilt square which is then assembled. "My grandmother used to [assemble it] and my other grandmother is going to be helping her. The quilt is presented to the couple after the baby's arrival, to celebrate the newest member in the family.

Although these practices represent a ritual and/or a celebration to welcome the baby, they do not represent care or support for the new mother.

Four couples (27%) represented by one expectant father and three expectant mothers described rituals or traditions that represented some degree of caring and nurturing for the new mother.

One expectant father stated,

My mother's going to come up for a couple of weeks right about the time the baby is born. That's sort of a ritual. That is a ritual! She does that with all the kids. She stays for a couple of weeks, just to help out, especially with a new mother. My dad usually doesn't come.

One participant stated, "The mother of the mother comes and stays for a week." This participant didn't view it as a ritual per se. She said, "It's something her mother did and she's going to."

Two participants, one from Canada and the other from Ireland, stated that if they were in their homeland they would be cared for by their mother, siblings and extended family in the immediate post partum period. One of the participants anxiously awaited her mother's arrival. I asked her what she

expected her mother's role to be.

Well, I think I doubt my ability to look after a baby. I feel that I'm not going to know what to do. I don't know what a baby needs. I think my mom would know. It would come quite natural. I'd like somebody experienced to be there when I say, 'What do I do? How do I hold it?' It's just the security of somebody that knows what they're doing. Moms come in very useful.

The other participant stated that if she were living in her homeland she would receive an abundance of support from her parents and extended family. She, however, did not anticipate support from her family. She stated the distance was too great. She then qualified her comment.

I don't think it's a matter of availability. They don't speak English. I think they will feel very uncomfortable to stay here. I don't want to ask them. When I decided to come and live here it was my choice and not theirs. They found that pretty hard to have their oldest daughter living at a distance, even if it's not so far.

Clearly, what she doesn't discuss, but implies, is the tension and distance her decision to immigrate to the U.S. has created between her and her parents.

The limited responses related to rituals was not surprising. Based on the research findings of Stern and Kruckman (1983) I did not find it remarkable that most of the couples were unable to articulate any specific practices related to post partum care. The limited responses imply that most of the couples believe the myth that they should instinctively know how to care for their baby. This myth is further perpetuated by the medical milieu which focuses little on the post partum period.

What is interesting is that all of the participants agree that the arrival of the baby will disrupt their present life style, rhythms and routines, which one could view as rituals. There appears to be, however, no definitive measures that they will employ to help re-establish those routines and rhythms.

As stated by Moustskas,

The realization that with all else in growth, in resolution of issue, in dealing with tensions, in renewal of life, a rhythm must be established between self and world, between self and other.
(Moustskas, 1981,p.15)

IV Play

The participants were asked about their memories of play. Most described rich play experiences. Examples included making forts in one's apartment, playing with friends and siblings, playing in the woods, frolicking in the barn , involvement in fantasy play or participating in school sports. Some recalled playing with a parent. Others stated that their play was supported by a parent. One participant spoke about his wife's play experience.

I am entirely jealous of her childhood, especially her relationship with her father and stepmom. Her parents played with her all the time. Neither of my parents were much into playing.

All of the participants stated that they have not stopped playing. Many described their play as either transformed or containing remnants of their childhood play. One participant described a variety of play experiences ranging from sports to exploring ponds and swamps around his house. He said, "Growing up, my dad would train me in baseball. He was a coach and he wanted me to do well." Presently this participant devotes some of his free time playing and coaching a softball team.

Another participant described how his fifteen years of playing Dungeons and Dragons with the same group of 'guys' has transformed into a business, which he described as the next step up from Dungeons and Dragons.

One participant described how his playing strengthened his relationship with the members of his family. He remarked,

Playing. I was very free. My growing up was very free. I had restraints, like come home for dinner. I played with my sisters. One thing that stands out in my mind is that family, your family were your best friends. If you had any problems in the world or wherever in the neighborhood, the place you could come for comfort and support is family. I am very close to my sisters and I would play with them.

He stated that his parents were involved and supportive of his play. He described play activities with his parents as building forts and tree houses. The family skated, sledded and skied together.

In contrast one participant stated that it was so long ago that he couldn't remember. I asked him if he remembered playing with other kids. He responded, "I played with neighborhood kids. Got into fights with them, that's about it." I pushed . "What about school?" I asked. "It was just in and out, did my work. I never really associated with too many people in school. Not too many friends."

His response is similar to responses I heard from the emotionally disturbed children I interviewed as part of the hospital pre-admission assessment. His lack of friends and play experiences were disconcerting.

Similarly, one participant, who is not included in the overall results of the study, reported having had no play experiences as well.

Well, unfortunately, I didn't have too much of a childhood because my parents were so sick that we had people coming into the house taking care of us and my mother was taking care of my father. I was basically playing an adult before I was even ten years old. My childhood wasn't. It didn't come. I can't remember. We had a bike. I used to play with Barbie dolls a lot. I was pulled right into taking care of my sister and brother.

She had no recollections of playing at school or playing with classmates.

Her account was similar to the narratives I had heard from the parents of the hospitalized children in my play study (Fraktman, 1992). Throughout the interview her responses heightened my conviction that she required maximum

support to assist her as she transitioned into the parenting role. At the end of the interview, I asked her if she would be interested in receiving post partum support from an organization, Visiting Moms Program (See Appendix). She agreed. I made the referral. A representative visited her and conducted an assessment. Her findings concurred with mine.

Evaluating the Play Element in the Assessment Protocol

All of these responses strengthen my belief that including questions regarding one's memories of play should be included in an assessment interview. It begins a dialogue with an individual about their earliest socializing experiences. It provides a window to view the lighter side of one's experiences. It provides information about one's ability to sustain a relationship. It provides insight into an individual's capacity to negotiate, compromise, as well as add laughter and frivolity to a relationship. As Moustakas suggests,

Play is the source of creative experience, new energy and new feeling. The play process is the path of self confidence, self esteem. The child who is able to be lost in play, to create in play is assured a source of strength that makes possible the overcoming of difficult situations. (Moustakas, 1981, p.20)

The Most Significant Factors of the Protocol

The most compelling indicators in the protocol that appear to effect a smoother transition into the parenting role are item V, Ego Development, item VII, Nurturing and item VIII, Shared Responsibilities. Information gathered from these particular sections provided insights about how the individuals functioned both independently and as a couple. It revealed how the couple has thought about and planned for the arrival of their baby, thus providing a window for assessing the amount of necessary post partum support.

V Ego Development.

Asking an individual to describe oneself is a routine component of a psychiatric assessment used to obtain information about an individual's ego development. Many individuals had difficulty with the question, "Can you describe yourself?" I often had to reframe the question by asking participants to identify their strengths. I then asked them to identify either the personal qualities that they felt they needed to improve on or to describe their shortcomings.

Responses in this assessment interview corresponded with characteristics related to ego development which, in previous research, predicted a smooth transition to the parenting role. Similar to Vondra's (1993) findings, individuals who possessed components of a strong ego, i.e. flexible thinking, interpersonal trust, active coping and an ability to develop and maintain close relationships appeared to exhibit those qualities in their dyadic relationship. The couples with these traits were not assigned an indicator on the item. Conversely, those couples who identified characteristics of poor self-esteem, inflexibility, and/or lack of friends in their responses were assigned checks on those indicators because they predicted they would require more support in the post partum period. Cowan and Coie's (1978) research highlights the importance of possessing a strong sense of self which influences self-esteem. Self-esteem, which Daniels and Weingarten (1980) identified as an important characteristic necessary for a smoother transition to the parenting role, became evident in some of the responses which helped to determine how receptive one might be in soliciting and/or receiving support.

Similar to the findings of Vondra (1993) and the earlier research of Belsky(1984), ego functioning proved to be a strong predicator in how the individuals functioned both independently and within their dyadic relationship.

Vondra's(1993) research suggests that one's psychological functioning may serve as a link between one's individual adjustment and the marital relationship. The findings from this study support their research.

One example is Frank. Throughout the beginning portion of the interview, Frank rocked incessantly. When I asked him to describe himself, he stopped rocking, sat in silence, for what seemed several minutes, and then began to speak.

I would describe myself as someone with foresight, thinking ahead type person, scheduled type person. I'm an engineer. That kind of goes along with being an engineer. Methodical and numbers. I like order. Organized, yet sometimes, I think, just a little lazy. A little bit scattered. I'm organized, but sometimes I try to juggle too many balls at one time.

When I asked him about his shortcomings he replied, "Selfish, lack of deep concern for people and situations." However, he stated that the pregnancy experience, especially in the first trimester when his wife was "sick" had helped him become more sensitive to people and aware of stressful situations they may be experiencing.

His partner Maureen, described herself as out-going and friendly. She admits that she has a tendency to be emotional. She stated,

I really care about people. I think I've learned the limits of really being able to take on other people's burdens, especially my family. I finally can see things more objectively. It's been great because I feel like I've really pushed through that and not allowed that to happen. I feel like I've grown.

She described her downfalls.

I think I get too serious, sometimes. Sometimes I let my past [victim of sexual abuse] affect me. That's kind of constant. It's like a constant haunting thing. It rears its ugly head and I know I have to just learn how to deal with that and move on. But, that's hard sometimes.

In spite of her past history and the "flaws" that they both describe in

themselves, they both demonstrate the ability to change and grow. They both revealed self reflection as part of that growth process. Both of these attributes contribute to the strength of their ego development.

Daniels and Weingarten's (1980) research suggests that self esteem contributes to one's ability to feel worthy of receiving help or support. This research supports their findings. Monica is an example.

Monica is a 33-year-old woman, who had difficulty describing herself.

She stated,

I'm a very simple person. I'm kind of intelligent, not overly, Gerald will tell you. I like going for walks. I like being married. I like being pregnant. I'm very content.

She described her shortcomings.

Probably my biggest weakness is my inability. I have great intentions of doing things. I mean, I always say I'm going to do a class. I'd love to go back to college. I'm going to do this, I'm going to do that and I end up really doing nothing. Yet, I'm not a lazy person.

Her description of herself appears to convey a lack of self esteem. She defers to her partner to substantiate her intellectual capacity.

The Assessment Protocol indicators summarized on item V, Ego Development support the research findings of Belsky (1984), Vondra (1993), Daniels and Weingarten (1980), and Cowan and Coie (1978). Of the seven (47%) couples who were categorized requiring minimum support, two, (29%) identified one indicator apiece. In contrast the seven couples (47%) who were classified as needing moderate support, five(71%) identified a total of twelve indicators related to poor ego development.

The only couple (6%) who was placed in the maximum support level accrued six indicators on item V. Examples for her represented Poor sense of one's own needs, Controlling, Non-adaptive to change, and Perfectionist. His

represented Excessively independent and Lack of friends. The participant who did not complete the study was assigned two indicators on item V. They represented, Poor self-esteem and a Poor Sense of one's own needs (Worthiness).

Christine and Greg's responses help to illustrate how information about oneself can provide insight into how one functions and what they bring to the relationship.

When I asked Christine to describe herself she replied,

Obsessive compulsive. Anal. Neurotic. Everything has to be just so. Everything in my house has a place. If Greg moves anything I freak out.

She stated that she exhibited this behavior even as a child. She remembered that if her glass figurines had been moved in the process of having her room cleaned she would know.

I would not go outside. I would not do anything until those figurines were back exactly the way they had been. I'm just obsessed. If it's not just so, you can't deal with me.

I asked her to describe her experience when something is out of place.

She replied, "I get confused. I get very disorganized. I have to fix it."

She described the T.V. remote control as an example. "If I put the TV remote control down on the placemat and if it is moved from the placemat I go crazy."

She described spending twenty minutes in the morning, before her interview with me, searching for a hi-lighter that was displaced by her cats. Her partner suggested she use another one. She refused. She listed many reasons why she had to have that particular marker. She stated, "I just get very confused, very disoriented, discombobulated."

I asked her how this behavior would "fit in" with the new baby. She responded,

I think I am going to go crazy. I think I am going to start the line of mental illness in my family. I know babies don't work that way. I know I have to find a way to re-align myself, to make myself learn that it's okay if things aren't in place. I don't know what I'm going to do.

She described how she would yell at her partner when they started dating. She admitted,

I never meant to bite his head off, but I got so used to having things my way, everything just so. I don't know what I'm going to do. I'm probably going to start the line of mental illness in my family. I'm going to be the first in the line of mental illness. She described herself as being very organized.

I have my little book called, 'My Life.'. If 'My Life' is somewhere and I'm not with it, I'm not where I'm supposed to be. I write everything down, everything.

She described herself as self sacrificing. "I tend to put everybody else before myself." She described her shortcomings as being "really stubborn."

I'm also obsessive/compulsive and anal, which is also kind of bad. I guess the obsessive thing is probably good in some ways, but it's really going to be bad when it comes to the baby. I hope I can get rid of it. But, I don't think it's going anywhere in the near future.

I was so concerned about this woman that I conferred with a colleague, who is a psychotherapist. She treats women, specifically, during pregnancy and post partum. She strongly suggested that this woman seek treatment before she delivered her baby. I contacted this woman and expressed my concerns and my colleague's strong recommendation. I gave her my colleague's phone number with the hope that she would contact her. She never did. It is interesting to note the number of times this woman repeats the statement (concern) that she is destined to be the first in her family to be stricken with mental illness.

I asked her partner, Greg, to describe himself.

He said, "Bull headed, stubborn, very giving. Trustworthy. I want people to trust me." He identified his strengths as, "I'm always there if someone needs

me. I'm 99% of the time on time, very punctual. I take orders well." He described his shortcomings as, "Sometimes I say things without thinking. I'll voice my opinion before I think. I'm quick tempered."

Greg described himself as a loner, which is a continuation of his younger years. He stated that he had few friends growing up. He said, "I pretty much isolated myself from everybody when I was growing up." That pattern appears to have persisted into his adulthood.

Not too many friends, more acquaintances. It's easier on the work mind. People at work, they like to gossip just like my family.

In contrast to Christine and Greg's description of themselves are Carla and James. James described himself as,

Trustworthy; an honest person and very direct and straight forward. I'm giving, probably a little too much. I like to have a good time. I have a strong work ethic. I'm either working or I'm playing. I try not to cross them in between or send out mixed messages. I work with kids a lot, so I try not to send a mixed message. I can be fun, but I can also be stern.

His partner, Carla, described herself as, "Very sensitive, emotional, caring and family oriented. She described her strengths as "Very organized, supportive of folks that I have a bond to or care for." She described her downfall as being moody sometimes.

They both identify a circle of friends that they socialize with as a couple and independent of the other. Carla and James did not receive any indicators on item V, Ego Development as opposed to Christine who was assigned four indicators and Greg two on item V.

The research of Belsky (1984, 1994), Daniels and Weingarten (1980), Lewis (1988), and Vondra (1993) support the premise that the psychological strengths that an individual possesses is a factor that contributes to the individual's ability to function as a couple.

How Individuals Function Within the Dyad

In order to understand how the individual functioned within the dyad I began with questions related to what makes one upset. I followed with questions that would help explain how an individual manifested an upset state. I then asked, "Is your partner one who can help you when you are upset?" I asked, "Are you able to comfort your partner when your partner is upset?" These questions began a dialogue related to one's ability to comfort/nurture each other. It shed light on one's ability to receive comforting from another. This attribute is one that Lewis' (1988) research uncovered as important in determining how smoothly a couple is able to incorporate the baby into their family unit. He further suggests that attributes of sharing vulnerabilities, nurturing one another, sharing "power" in the relationship and role flexibility are additional factors that influence the ease in which a couple is able to incorporate the baby into their family unit. Based on Lewis' research, I followed with questions pertaining to decision making power that the individuals exerted in the dyad. Role flexibility as opposed to rigid traditional role functioning was another predictor of a smoother transition into the parenting role. I explored how individuals shared time with each other. In asking the participants what activities they pursued without their partner, I attempted to develop an understanding how independent each individual was within the context of their dyadic relationship.

The couples who placed in the minimum support range on the assessment protocol were couples who shared in household tasks equally with role flexibility. These individuals felt they could effectively comfort their partner and their partner was receptive to the nurturing efforts. Partners openly agreed that the comforting efforts were appreciated and well received. Some of the

partners were less convinced that their efforts were helpful, but hoped they were. Decision making "power" was equally shared. Most of the couples functioned well independently and maintained their own circle of friends.

Carla and James accrued a total of twelve indicators on the assessment protocol that placed them in the category requiring minimum post partum support. They have been in the relationship for two years and they are unmarried. They are a couple who describe role flexibility, compromise, and an ability to nurture one another. I asked Carla if James was someone who could help her when she was upset. She said he did. "Just being there to discuss things and help me think in a different light." I asked her if she is able to help him when he is upset. She stated that she could. She stated that her approach was similar to his. She enjoys doing activities with her partner, but is equally comfortable spending time with some of her friends or family. When I asked about major decisions she stated, "We're learning how to discuss them together. It's not like one person dominates in the decision." She confessed that she had agreed to participate in this study without consulting her partner. She repeated, "We're learning. We're partners now." She described the household chores as shared and flexible. "Whoever sees it needs to be done, it gets done."

She said cooking was another story.

He cooks better than me. I have a little complex about cooking for him. He might not like it so I don't try it often. He bought me these great recipe cards for Christmas. He tries to encourage me to cook more. Cooking is something I have to work on.

Carla stated that the decision to move in with James tested their relationship as a couple.

I finally moved my stuff here. This is his home. When I found out I was having a baby we decided that it would be better if we lived together and tried to become a family.

She stated that the move took about three months before she had moved all of her things in. She stated, "I couldn't understand it, what was the struggle? I lived with my grandmother before I moved here." She spoke of this move as an adjustment for both of them. He accused her of moving everything around. He couldn't find things. She talked about her adjustment. "I used to say things like 'your neighbors' and he'd say, 'they're your neighbors, too; you live here now.'" She stated,

It was kind of difficult for both of us. He felt like I was throwing all of his stuff out and I was just taking over. I was just trying to fit my stuff in so I could feel at home. It was rough, but, we've gotten past that now.

Her description of the move vividly depicts the strength and commitment that this couple bring to their relationship. Their ability to compromise, yet retain their own sense of autonomy, supports Lewis' (1988) definition of a highly competent couple. Their ability to resolve their difficulties in a constructive manner supports one of the themes that Belsky (1994) uncovered in his research regarding a couple's ability to smoothly transition into the parenting role.

James stated that Carla is someone who is able to help him when he is upset. He said, however, "I usually try to do it myself." He described strategies that he employs that ranged from a time out, to being alone or going to sleep "when things might get out of hand." He agreed that he is able to help Carla when she is upset. He qualified this by saying, that he will make an initial attempt to be comforting. If the person does not respond he stated that he'll just leave them alone. "I'll give her some space. I try to treat people the way I would want them to treat me." He stated that he and his partner share activities and do activities independent of each other. When I asked about household chores he responded, "Split right down the middle."

Role flexibility and shared responsibilities are characteristics that Lewis (1988) describes as attributes that contribute to a highly competent couple. Both participants appear to be actively working on making changes to strengthen their relationship. Both of the individuals have a positive sense of self, an openness to new ideas and experiences, and a belief in their ability to make changes, which Belsky and Vondra (1993) describe as a link between marital satisfaction and individual adjustment. James' encouragement of Carla's cooking and her receptivity to learn are an example of those attributes. Carla did not receive any indicators on items VII, Nurturing and VIII, Shared Responsibility. James was assigned one indicator on item VII, Nurturing, which is based on his description of his nurturing strategies. He did not receive any indicators on item VIII, Shared Responsibility. These results predict that this couple are more likely to transition into the parenting role more smoothly. It appears that they will need a minimum degree of support.

Christine and Greg provide a dramatic contrast. I asked Greg if Christine is able to comfort him when he is upset. He replied,

To be honest with you, I don't really know. We've gotten into fights. I've walked away and she's walked away. We end up calling each other later and working it all out. Usually it gets to the point where everything blows up before we can actually fix it. It's something that we have to work on, or I have to work on.

I asked him if he felt that she was able to help him when he was upset. He replied, "She's a good listener." I asked Christine if Greg is someone who can comfort her when she is upset. She responded, "I don't like being consoled when I'm upset. I just need to let it out." She stated that she often uses Greg as the scapegoat, screaming and yelling at him. She was quick to say that he thoroughly understands that she is not yelling at him, but rather, that she is just upset. She says that he is very understanding.

I asked Greg what activities he enjoys with Christine. He stated that he and Christine enjoy going to the movies, playing pool and miniature golf. The activities that he enjoys without her include hunting, fishing or shooting (target practice) all of which, he stated, were solitary.

I asked how household chores were divided between them. He described some of the tasks that he is responsible for. When I asked if they were divided evenly, he responded,

I try, but I get in the way more than anything. She has a certain pattern of doing things. If I do something it throws everything off and she gets very confused.

Her obsessive behavior influenced how they, as a couple, made major decisions. He stated,

She makes them all. I just agree with her. There's no sense in arguing. She's going to do whatever she wants anyway. I voice my opinion, but, that's about it.

Her version of the decision-making process was slightly different.

We think about it on our own, we come together and discuss our ideas and then, whichever one wins out, unless we agree. I think I win more than he does. I guess I tend to win the major discussion issue. We tend to go with what I want to do or my decision. I think that's more because he was brought up with, 'Whatever makes her happy,' whoever 'her' is. Whatever makes her happy, you do.

Her previously discussed obsessive disorder and his asocial behavior directly influence how they function as a couple. They demonstrate inflexibility in role responsibilities and decision making power, two characteristics, according to Lewis (1988) that have proven to be important indicators related to a couple's ability to transition smoothly into the parenting role. Her inability to be comforted has a direct bearing on her receptivity for post partum support. Christine received two indicators on item VII, Nurturing due to her inability to nurture her partner or be nurtured by him. She was assigned one indicator for

item VIII, Shared Responsibilities because of role specific tasks that she adheres to. Greg also received two indicators on item VII, Nurturing, since he did not perceive that his nurturing efforts were effective. In addition it did not appear that his partner was able to nurture him. He received one indicator on item VIII, Shared Responsibilities which related to the lack of his decision making power. The number of indicators that this couple received predicts their need for maximum support.

Evaluating Ego Development, Nurturing and Shared Responsibility Elements in the Assessment Protocol

Ego Development, Nurturing and Shared Responsibilities are the most compelling indicators related to the ease in which the couple will transition into the parenting role. They are strong indicators of the degree of needed post partum support. Organizing the three elements under the category such as Marital Competence may be more succinct when utilizing this assessment in the future.

VI Level of Energy

The purpose of inquiring about the individual's level of energy was to understand better how well the couple would cope when exhausted and sleep deprived. In addition, it is a strategy, often referred to as anticipatory guidance, that is implemented to initiate a dialogue with the individual for the purpose of preparing one to explore available resources for post partum support. It is a way that can inform the interviewer of the amount of post partum support one may require. As part of this inquiry I asked couples to describe the amount of sleep they required. I then followed with questions that would help me understand how one copes with less than one's normal required amount of sleep.

Nine couples (60%) identified some aspect related to the level of energy

that would potentially impact either on the post partum recovery or post partum support. Six (33%) individuals, (three males and three females), of the nine couples identified difficulty napping when tired. This information is important because napping when the baby is sleeping is a suggested strategy to counteract the fatigue one experiences when sleep deprived. Four (22%) individuals, (two men and two women), described a variety of untoward reactions they would experience if they did not have their required amount of sleep. Two (11%) individuals, (one male and one female), described themselves as workaholics. Excessive working can impact on one's physical and emotional availability in the immediate post partum period. One individual (5%) needed a schedule. Newborns are ignorant of external schedules. How well the adult would adjust to the interrupted schedule can be a concern.

A few examples help illustrate what some of the participants experience when they do not get the required hours of sleep. Jim, who requires a solid eight hours of sleep, said,

I start to forget things. My body doesn't work quite right. I just don't feel right inside. It's like my body quits going in the right direction.

Interestingly Jim voiced his concerns about how he would function as a sleep- deprived parent with a new baby in the earlier portion of his interview.

If Barbara, who requires eight to ten hours of sleep,. doesn't get enough sleep, she stated,

I feel awful. I get cranky and kind of weepy. I cry at the drop of a hat anyway, but I get this kind of on the edge feeling. I just need my sleep. It feels just too awful to not get it.

Sonia stated,

If I don't get enough sleep I get headaches. I get depressed sometimes or I feel sick. Sometimes I get sick with a cold. It's really important that I get enough sleep.

I asked her how she planned to manage getting adequate sleep with a new baby. She said,

I have thought about it. I'll end up sleeping whenever I can. Dick will help a lot. My mother-in-law is going to stay with us for awhile. She'll help.

Doug is an extreme example of how a person's level of energy will directly influence a couple's need for post partum support. He described himself as self motivated and very determined. He said,

I have no patience. I'm a perfectionist. I have Muscular Dystrophy, so I try to make my life easier. Very simple, I want to take care of it now and not have to worry about it later. I want to make my life as easy as possible.

The disclosure about his chronic illness led to questions related to his level of energy. He stated, "Mentally my energy level is very high. Physically my level of energy is very low."

I asked him how he responds when he doesn't get an adequate amount of sleep. He reported, "Extremely irritable, grumpy."

He described his work schedule as busy for four or five days followed by a self imposed period of complete rest. "I need to rest, regenerate, recoup." He described the physical exertion necessary to bend and pick up something like a paper clip or bar of soap. He said,

It's very limiting for me. I don't want people to pick up after me. I want to be able to do it myself like I used to be able to. I have to allow other people to pick up after me. It's very hard.

This disclosure can assist the interviewer in helping the couple think about and plan for post partum support.

Evaluating the Level of Energy Element in the Assessment Protocol

Including questions related to the level of energy was important and worthwhile. As demonstrated by the examples, the information gathered related

to the level of energy helps to understand the degree of post partum support that may be required.

IX External Stresses (Recent Life Events)

The significance of identifying recent life events cannot be overstated. From an ecological perspective it is a reminder that human development is embedded in one's environment and activities of daily living. It was an important question to ask the participants in order to develop an understanding of how those life events might contribute to the existing stress of the pregnancy. Further, it provided information that could affect an existing plan for post partum support.

I asked one participant if there were any recent life changes. He jovially responded, "Other than a whirlwind courtship, getting married [one year ago] buying the house, having a baby. Other than that, no. He paused and added,"

Just before that, I was diagnosed with testicular cancer, which is my second go around with that. The first was fifteen years before. [1977] That happened four or five months before I met Heather.

Another short pause followed.

A job change; I started a new job just last November. I had been working for myself for the last five or six years. I went full time with a company and now I'm about to back out and go part time.

This job change would allow him to work several days at home. He viewed this change as an asset since he would be more available to help with child care and home maintenance.

The reality of a serious disease, which can render one infertile, requiring an intense treatment schedule, sheds light on the couple's excitement about this pregnancy. Being more available at home initiated a discussion related to his

availability as a support resource in the immediate post partum period.

Another participant stated,

Well, my father just retired. That's a big life change, this past weekend as a matter of fact. He lives a divided life between France, living just outside of Paris, and Princeton, New Jersey. He's an academic. Just the fact that he's retiring is a reminder of his mortality. One of the things that was an impetus toward when we should have the baby and one of the things that was very important in my mind was that I want my child to know my father.

He reported that his father-in-law passed away a few years ago. He confessed that he hadn't even mentioned these thoughts to his wife. "For some reason it popped in my head that I want to make a concerted effort to spend more time with my father." He spoke of the family system comprised of two mothers and a stepmother, all of whom are much younger. "In my mind his retiring makes me think of weighing it toward him in terms of how we spend our time." I commented that it sounded like the pregnancy had stirred up thoughts about his father. He replied,

Yeah, in a good way. I mean, bittersweet. As much as my father wasn't playing enough with me when I was a kid, he's a great person and he is very special. I'm eager to have him alive and well to love my child.

This participant's comments are similar to comments I heard from expectant fathers in a research project I conducted in 1992. Similar to this expectant father, the pregnancy and the reality that fatherhood was imminent precipitated thoughts about one's own father. It was a time that the men began to actively reflect on their relationship with their father. It was a time that they began to identify what paternal attributes they wished to replicate. The death of his father-in-law in 1992 may have also contributed to his feelings of wanting his child to develop a relationship with his father.

To the recent life event question Doug responded, "Buying a house. We

own the condo upstairs and the condo next door." He paused and said, "Future. I guess acceptance of the future wheelchair." He spoke of how his physical limitations (Muscular Dystrophy) would force him to redefine how he functioned in his business.

I have to do a lot more communication by computer, fax, printing and photocopying. More stay at home business type of deal. Getting a wheelchair eventually is something I have to deal with.

His openness about his physical limitations was an opportunity to discuss his post partum support needs.

In addition to his chronic, debilitating disease, Doug and his wife Leah's move into their own condo has moved them away from a support network of friends and family.

Similarly, Sonia and Dick reported that they moved out of state, also away from a network of friends and family. Obtaining this information during the assessment interview helps to engage the couple in a discussion about support resources. It helps them to begin to think about exploring their new setting for available resources as well.

Bernice reported that her father had just recently suffered from a heart attack. She described how she is the one in the family who usually has to maintain a positive perspective because her mother tends to have a negative outlook. She stated, however, that this attitude is not usual for her. It becomes operationalized in a family crisis because normally, she confided "I'm just like my mother" with a negative perspective on life. The anxiety over the well being of her father added to the existing stress of the pregnancy.

In addition she stated that she and Jack had bought a house three months ago. "That's a huge life change." She stated that financially things appear to be stable. She paused and said,

I'm starting to worry now because I'm not going to get paid for three weeks. I have extended the leave. They're only paying me for seven weeks. I'm starting to get worried about money.

Being informed about recent events that add stress to the existing uncertainty and anxiety of the pregnancy helps the interviewer explore post partum support options. Bernice was relying heavily on her mother for support in the immediate post partum period. However, if her father took a turn for the worse, her mother might not be available. This information can initiate a dialogue with the couple about the possibility of developing a network of support options.

At the time of the prenatal interview, Frank had just accepted a new job. He would start in two weeks, which would coincide closely with the expected birth of his baby. I asked him if he would qualify for paternal leave? He was not certain. He thought that he would qualify for a three day paternal leave. His new job, with the pressure of wanting to do well, could create stress and even interfere with his availability in the immediate post partum period.

When I asked Chris about any recent life changes he responded,

"Eileen's sister just lost a baby. It was still born." He reported that Eileen's mother was flying out to be with her. He said that Eileen had comforted her sister via telephone.

Learning information of this nature can alert the interviewer that Eileen may experience additional stress as she nears the end of her pregnancy. Potentially, she may require additional support and reassurance about the status of her unborn baby.

Evaluating the Recent Life Events Element in the Assessment Protocol

As previously stated, including a question related to recent life events proved to be very beneficial in developing a better understanding of the couple

within the context of their total life experience as well assessing their post partum support needs. It is a question that provides an opportunity for the health care provider and the couple to engage in the process of exploring resource options and develop a post partum support plan.

Summary of the Assessment Protocol

The preceding pages have provided an indepth description of individual responses to the assessment interview. Following is a compilation of each support category which outlines a profile of the couples placed in a particular support category. A graph reflects this support breakdown on page 144.

Minimum Support

Seven couples (47%) had a total number of indicators that placed them in the minimum support category.

The number of indicators ranged from 12-15

Distinguishing features :

6 of 7 couples are married.

Length of time together as a couple ranged from 2 to 8 years

6 of the 7 pregnancies were planned

Age range: women 26-37 years men: 28-42

2 of 7 couples (1 male, 1 female) were assigned indicators on item V (Ego Development)

1 of 7 couples (one male partner received one indicator on item VII (Nurturing);

1 of 7 couples (both partners) qualified for one indicator apiece on item VIII (Shared Responsibilities)

3 of 7 couples received indicators on item IX (Recent Life Events)

The Most Important Indicators

The most important factors that contributed to these couples needing minimum support were either the absence or scant number of indicators assigned to the individuals on item V (Ego Development), item VII (Nurturing)

and item VIII (Shared Responsibilities). The latter two items assess dyadic functioning. Of the seven couples, 29% possessed an indicator on item V, 14% on item VII and 14% on item VIII. Of the seven couples, 43% received an indicator on item IX (Recent Life Events). In addition 86% of these couples had a planned pregnancy.

What was impressive about the couples who qualified in the minimum support category was not that they were free from stress or significant past histories, but rather, their responses reflected the individual strengths they brought to their relationship and how they functioned as a couple, both factors which support the research. Two of the seven women had experienced either a miscarriage, a spontaneous or therapeutic abortion.

Moderate Support

Seven couples (47%) had a total number of indicators that placed them in the moderate support category

The number of indicators ranged from 16-25

Distinguishing Features

6 of 7 couples are married

Length of time together as a couple ranged from 2-5 years

4 were planned pregnancies, 3 were unplanned pregnancies

Age range: women 27-40 years men: 26-43 years

5 couples received indicators on item V (Ego Strength) 1 male partner and one female partner given at least 1, 2 male and 1 female partners received 2 apiece, and 1 female received 4.

2 couples received indicators on item VII (Nurturing) 1 male partner apiece

4 couples were assigned indicators on item VIII (Shared Responsibilities)

2 male partners received 1, 1 male partner 2, and 1 female partner 1

7 couples had indicators on item IX (Recent Life Events)

The Most Important Indicators

The most important factors that contributed to couples requiring moderate support were the indicators accrued by 71% of the couples on item V (Ego Development), 29% of the couples on item VII (Nurturing), 57% of the couples on item VIII (Shared Responsibilities) and 100% on item XI (Recent Life Events). In addition, 57% of these couples had a planned pregnancy in contrast to the 86% in the minimum support group, a difference of 29%. The percentage differences between the moderate and minimum support groups are 42% higher on item V (Ego development), 15% higher on item VII (Nurturing) and the largest percentage differences of 43% higher on item VIII (Shared Responsibilities) and 58% higher on item IX (Recent Life Events). The moderate support group reflected poorer ego development, less ability to nurture the other and inflexible role responsibilities. The research has identified that these three attributes are significant indicators in facilitating a smooth transition into the parenting role. In addition it appeared that external stressors for the moderate group compounded the need for post partum support.

Maximum Support

One couple (6%) was assigned indicators that placed them in the Maximum Support category

The number of indicators was 33

Distinguishing Features

The couple is unmarried

The couple have been together just one year

The pregnancy was unplanned

Age range 23-26

On item V (Ego Development) the female partner received 4 indicators her partner received 2.

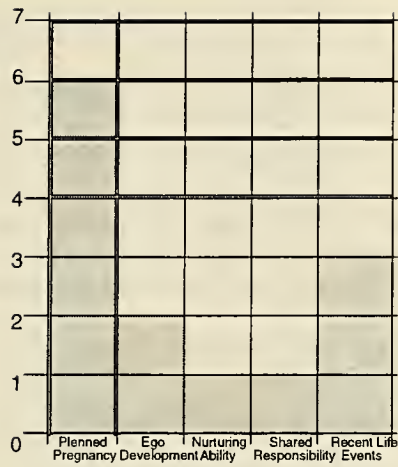
On item VII (Nurturing) both partners were assigned 2 indicators apiece

On item VIII (Shared Responsibilities) both partners had 1 indicator apiece.

On item IX (Recent Life Events) the female partner received 2 indicators.

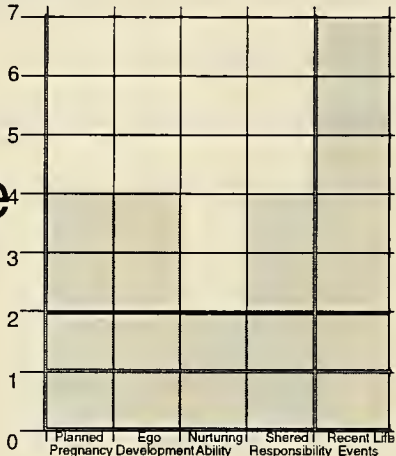
The Most Important Indicators

The most important factors that placed this couple in the category of needing maximum support are the number of indicators they scored on item V (Ego Development), item VII, (Nurturing) and item VIII, (Shared responsibilities). The research has identified that these attributes are strong indicators of how well a couple is able to transition into the parenting role.

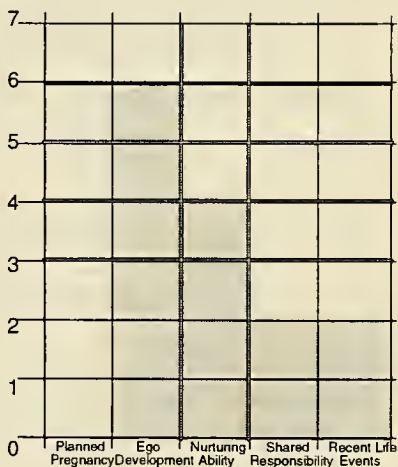


Minimum Support

Moderate Support



Maximum Support



Section III Support Plans

The Best Laid Plans

I asked each individual in the study what sources of support they had planned to utilize in the immediate and early post partum period. All the individuals identified some form of post partum support. Most of them, however, acknowledged that this was their first experience as parents, which made them less clear about the amount and type of support they would need. Many of their ideas were either based on observations or information from friends and family members who had recently become new parents. The couples' ideas of informal post partum support included "baby holding, taking care of me, giving advice, helping me be a mom, cleaning, doing laundry and going grocery shopping." The couples identified their partner, a mother, a sister, or a circle of friends who would most likely provide support.

A. Planned Informal Support

Some of the women expressed concerns about the support they had planned. Some brief examples follow. Linda stated that her mother-in-law had offered to come. She said, "It was a nice offer on her part and something I shouldn't turn down, but I have my concerns about her coming." When I asked her what her concerns were she stated,

She's just very controlling and very nagging. She a nice woman, but its her way or no way. And sometimes she becomes more high maintenance than the baby will be.

In contrast her partner, Ben, described his mother as doing "whatever is necessary."

She's very good around the house. I know she'll pull her weight, doing the laundry or cleaning or whatever needs to be done. She's that kind of person.

Maureen stated that initially she had some misgivings about her mother-

in-law coming to help. She stated,

I was kind of hesitant at first. I think, for me, it just brought up a lot of issues with my mom's death. I wish she was here. I wish it were her. It's been hard. She died eight years ago last weekend. I think that part of it [hesitancy] is that there's really nobody on my side of the family who's actively taking an interest. That does hurt, sometimes.

She paused and then approached her reticence in a more positive light.

I think for me it's going to help me just to be able to sit back and let someone help me and give to me. She added, I know he's excited to see his mom. She's going to be a great help. She's very real, down to earth and she just wants to be a support and not hinder or get in the way.

Many couples identified friends as part of their support network. Some identified a circle of close friends they felt comfortable soliciting if they needed assistance.

Since Barbara's parents lived in the adjacent town, she said that they offered to provide the support in the immediate post partum period . Bruce's mother lived out of state. She planned to come several weeks after the birth of the baby. Bruce stated that they had a circle of friends who they could enlist as the back-up plan. He, however shared his ambivalence. Bruce stated,

We have a close-knit group of friends that will be glad to help us out, but I'm not gearing up to depending on that. I've been living on my own for nearly twenty years. I am more than willing and open about getting help from people and not trying to depend on them to do it.

Leah and Doug have recently moved into a condo that they had purchased. The move has separated them from friends and family. Leah said that her long commute to her job has prevented her from getting settled into this new community. When I asked Leah what support she anticipated she would need she replied,

We're really not planning on anything. We've had some offers. My sister and Doug's mother both offered to come and stay. I'm sort of saying 'wait and see.' If I really don't need the help, I'd rather have peace and quiet than feel like I'm having to entertain a guest here. I'm not sure how much help the offered help is going to be, even though it's offered in good spirit.

Doug reinforced the idea that his mother would help. He identified his sister as another source of support since she lives in the same condo complex. Doug's physical limitations (Muscular Dystrophy) and his need for adequate rest may impact on the type and amount of post partum support he would be able to provide. The compensatory behaviors that he employs to maximize his level of energy and daily functioning in his business has often created tension between Leah and him. He stated that he has very high standards. When I pursued his definition of high standards he replied,

Very organized, I'm extremely organized. I'm also dyslexic so if things are not in the right order, or in the right spaces where I can't go immediately in my brain to put my finger on it, I become very disorganized. I become very disoriented. I become very agitated. I do the things that I do to make my life easier to streamline my thought process so I'm not expending needless energy. We do have a lot of arguments over expending needless energy. I need organization and structure. Without it I'm a complete loss.

Attempting to incorporate a baby into their family unit will compound that level of stress. Assisting this couple to develop a post partum support plan would appear vital as they recover from labor and delivery and begin to adjust to life with a baby.

Sonia and Dick have also recently moved to a home they purchased, which is out of state. She acknowledged this separated them from family and friends. She stated that Dick and her mother-in-law will provide the support in the immediate post partum period. She anticipated the support will primarily be helping with household chores, shopping and some help with the baby.

Monica's parents were coming from Ireland to provide support. Their expected arrival was approximately two weeks after her due date. She confided that Gerald would provide the support until their arrival. She worried about the possibility of an early delivery that would put additional stress on him to provide support. She said,

It would be tough for him because he's at a job that is kind of demanding of his time. Being self-employed it's not as if he can get time owed.

She added that until her parents arrive Gerald is her only source of post partum support. Gerald agreed that he would help as best he could. He stated,

Maybe the woman downstairs will help us out a bit. She had a child recently, so she's experienced in the motherly business, shall we say.

Christine and Greg do not live together. She states that the apartment is too small. As a result, she plans to stay with her parents who will provide support in the immediate post partum period. She said,

I'm going to my mother's house to spend a week. I'm staying with her for a week and Greg will be staying at my place to take care of the cats. Then I'm going to go home with Greg. He's taking that week off. He'll spend the week with me, helping me out.

She added, "This is going to be a big event, which I would rather it not be."

B. Planned Formal Support

The sources of formal support that the couples anticipated would be available to them in their first post partum week included a home visit by either a registered nurse or midwife and telephone calls from a professional, either a nurse, nurse practitioner or midwife. They expected that the baby would go to the pediatrician within the first two weeks. Three couples (20%) anticipated a home visit from a visiting nurse or midwife as part of their health insurance

benefit. Since Chapter 218, the act of 1995, which regulated a mandatory hospital stay was signed by the governor on November 21, 1995 and became effective, February 21, 1996, five women (33%) were not protected and could be discharged twenty-four hours after a vaginal delivery without any mandated formal support provisions. Those couples who delivered after February 21, 1996, qualified for a home visit from a professional if they elected to leave the hospital before 48 hours after a vaginal delivery or 96 hours after a Cesarean delivery. All the women (100%) anticipated a visit to their obstetrician or midwife six weeks post partum.

C. Results of Participants' Review of Support Options

At the end of each interview I asked each participant to review a list of formal support options. (See Appendix) I instructed each one to select the choices that he/she felt would best meet his/her needs after arriving home from the hospital with the baby. An individual was allowed to check more than one of the options. The items were arranged to begin with the least degree of support, e.g. Telephone calls, to the most amount of support, e.g. Home visits that were spaced over a period of eleven weeks. Space was allotted for hand written personal comments or suggestions.

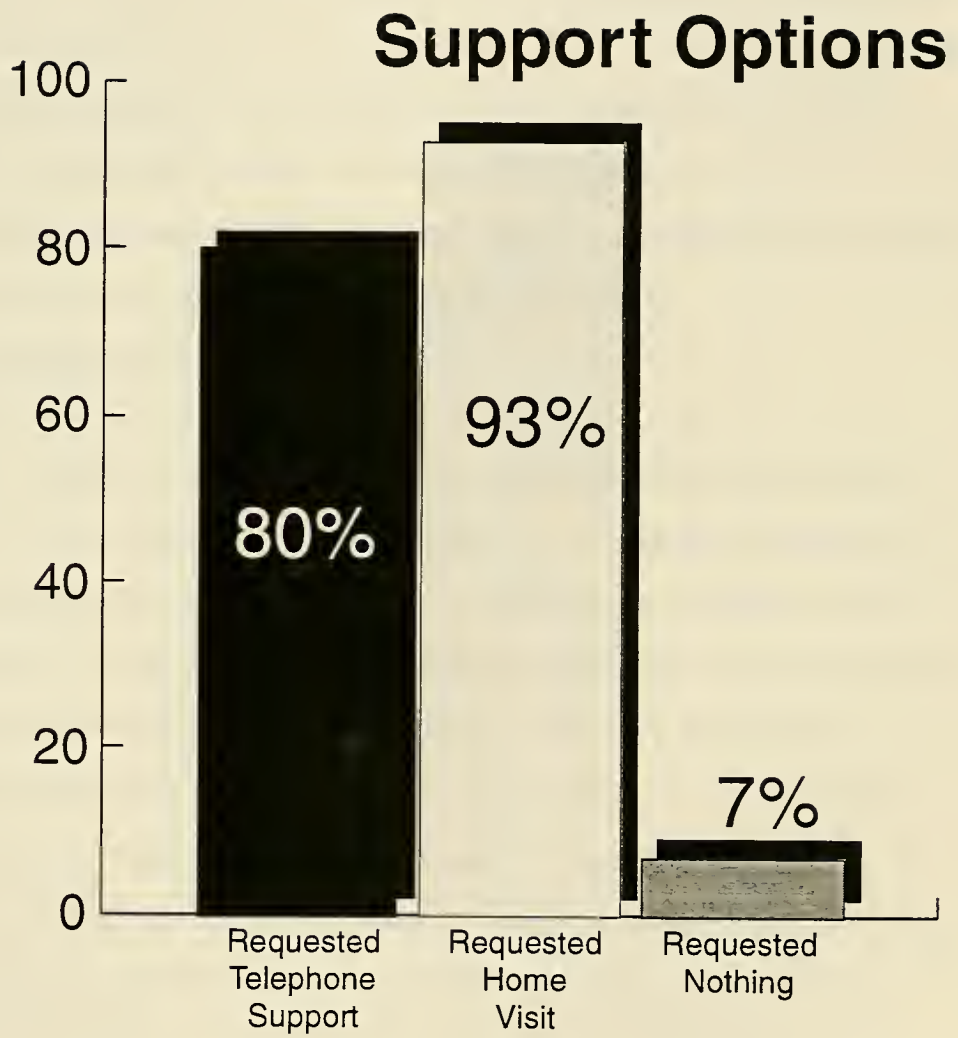
All but two participants (93%) perceived that they would need some degree of formal/professional support in the immediate and early post partum period. One female and one male selected the None of the Above item. Twenty-four (80%) of the participants, thirteen women and eleven men selected telephone calls as one form of formal support. The telephone call item most frequently selected by (33%) of the participants, N=10, six women and four men, consisted of Telephone Calls every other day for one week from a supportive professional. One Telephone Call in the first week was selected by 27% of the participants, N=8, five women and three men. Daily Telephone Calls for one

week was selected by 20% of the participants, N=6, two women and four men. All (93%) but two of the participants selected some form of a home visit. There were a total of thirty-three responses, sixteen female and seventeen male responses. The home visit selections that received the most responses were One Home Visit the first week home with the baby, receiving four female responses and two male responses; and Two Home visits week one followed by one home visit the next two weeks, receiving three female and three male responses. The home visit item receiving the most male responses was One home visit for the first four weeks. Several of the participants suggested additional support options. Three women suggested formal breast feeding support. One of the three suggested a lactation consultant. One woman suggested a Resource List while another woman suggested a Mother's Group. Five men shared some of their ideas, which included: Access to a professional by telephone, a telephone number one could call with non-emergency baby care questions, a support group for new fathers, an available nurse or parent knowledgeable of parenting skills or ideas, and a packet outlining what the couple would need in the immediate post partum period.

Discussion

What these results appear to imply is that, in spite of the fact that all of the participants agreed that they did not know what to expect or how they would feel in the immediate post partum period, most perceived that they would need to combine their planned informal support provisions with some formal support. It is not totally clear why the two participants made no selections. Both participants had made provisions for informal support. Attempts to further evaluate these responses revealed no patterns or differences observed by indicators for support. Not one group of individuals had more insight than the other. This information is consistent with the findings in this study. Expectant

first-time parents do not know what support they will need in the immediate and early post partum period. The written suggestions related to breast feeding continue to demonstrate that breast feeding is not an instinct, but rather an activity that women want assistance and support. Access to some form of resource lists and telephone numbers again accentuates the lack of support and available information specifically related to the immediate post partum period.



Section IV Planned Support Breakdown

A. The Best Laid Plans Oft Times Go Awry

Approximately one month after the birth of their baby, I visited each couple for a joint interview. I was specifically interested to learn about the effectiveness of their support plan. I was equally interested in soliciting suggestions that each couple believed would be helpful for future first-time parents.

For some the informal support plan did not come to fruition. For others the anticipated support fell short of their expectations. These factors support Vaux's (1988) position of employing an ecological model of support. To insure the delivery of a more comprehensive form of a social support system, he emphasizes the enlistment of both informal support, represented by one's social network, and formal support, represented by professionals.

1. Planned Support that Fell Through

Sally and Jim

Sally anticipated that her mother would come right after the birth of her baby and she would stay for about two weeks. She enthusiastically described what she expected her mother's role would be. "Mom is an old hand at all this stuff. She's going to help me be a mom!" She described her mother as someone who was very competent with a high energy level. Her partner voiced his expectation. "She's going to zoom right out here and help us get acclimated. She's going to make being parents easier for us." In actuality, her mother became ill just at the time that this woman delivered her baby. "That fell through which I was disappointed with." She came two weeks after the delivery and stayed for five days. A home visit from the midwife made up for some of the disappointment. "That was great, just because I wanted to see how the healing was going. I ended up calling the midwives pretty often. Examples that

precipitated the calls included questions about the stitches, bleeding, crying and not being sure about the feeding schedule. Another source of support for this couple was a two week stay with the paternal grandparents over the Christmas holiday.

He said, "It was wonderful. They loved to have him. They carried him around. It was just great to have a lot of help. You don't feel so isolated."

She added, "Yeah, it was great!"

2. Everything's a crisis!

Barbara and Bruce

In the prenatal interview I asked Bruce if he had developed any post partum support plans. He stated, "My employer is pretty flexible. It's a small company, so there is no real structure, like parental leave." He reassured me that his employer was very flexible. He said, "If I want to take two weeks off, as long as I was covered and my work is covered, I could do that." I asked him if he and his partner had planned on any other support after they arrived home with the baby. He stated, "Barbara's parents will be helping us out immediately. They live right here in town." He lamented that his entire family live out of state. "My sister and mother may come up and visit for a week, but probably won't stay any longer than that." He was quick to add, "We have a pretty close knit group of friends that will be glad to help us out." He thought for a moment and qualified his anticipated support network.

Barbara's parents are both elderly. I don't see them baby-sitting for hours on end. They don't want that. We've been told that, although that may change once they see their first grandson. I'm sure our friends will be over. But, they'll soon disappear. We go see our friends and the baby and then we leave.

One month after the birth of their son I visited Barbara and Bruce. I asked them to describe the events that occurred in the immediate post partum period.

He said, "I'm very happy to have a new baby, but it's been overwhelming!" He again lamented that his family lived so far away. "If my mother and my family lived closer they could have been over here quite often." He was quick to add, "Barbara's parents were great. They went shopping for us." She elaborated.

I don't think it's any one specific thing. I think it's everything together. It's the combination of lack of sleep, being first-time parents, the anxieties of every new little thing that comes along and where you're unsure of whether it's normal. It's like everything's a crisis. It's trying to keep the household going even if people are doing things for you, unless you have some kind of take charge person that comes in and says, *Okay, you don't have to worry about anything with the house. I'm going to take care of everything. We'll do the shopping for you. Don't worry about what we're going to get. I'll take care of it.*

She continued,

If you have to tell everyone what to do, then it's not the same as having to do it, but it still involves brain activity, which you don't really have the patience and the capacity for because you're so frantic about this little baby. So, it's nice to have someone, which we didn't really have, come in and basically just take over for you, so we didn't have to worry about that. My parents were wonderful, but still I felt like I had to coordinate everything.

It's worth noting that in the prenatal interview Bruce admitted that he was not, "a very good household person. "Although I try to keep it up, I'm not very good at it." This fact may have impacted on the situation. During the period of time that she was overwhelmed caring for the baby, he was unable to step in to help direct his in-laws manage the household and was unfamiliar with what needed to be done. To compound the situation, he was unavailable due to his work responsibilities. Bruce added,

It took me a week and a half to two weeks just to realize that I had to begin to change my life. We had trouble in the last month of the pregnancy. I missed a lot of work.

(He was taking Barbara to the physician for frequent visits to monitor her blood

pressure because she developed Pregnancy Induced Hypertension)

I missed a lot of work so when I got back I couldn't afford to take the time off. I had to just jump right back into it. I wasn't even off for the weekend. We came home Thursday night and I worked Friday.

She added, "His boss read him the riot act and he's worked ever since."

He said, "In three weeks before the baby was born I had only worked approximately thirty hours."

If Barbara had had her blood pressure monitored by home visits from a visiting nurse, she could have reduced the number of physician visits, thus lessening the lost work time for Bruce. He would have had more time to transition into the parenting role and be available to help support his wife.

Barbara stated,

The end result was that he was working and he wasn't around for the most part. It was just me, which wasn't great. I was breastfeeding, There was all that anxiety of 'Is he getting enough.' That was an added stressor. Plus the fact that obviously, if you're breastfeeding, nobody can give you a break and give a bottle, because you're the only one; you're the source.

It was clear that Barbara would have benefited from breast feeding support. She would have learned possible strategies that would have allowed the "break" she needed. A proactive approach of developing breastfeeding resources in the last trimester of her pregnancy would have potentially reduced some of her stress and feelings of being so overwhelmed. Further, this case is an excellent example of how the provision of a Doula can help ameliorate the *crisis*. Employing a Doula, as part of a social support plan, which is reimbursed by one's health insurance, cannot be over stated. If Barbara had a Doula, she would have had the opportunity to orient her to the household responsibilities before the birth of the baby. She would have had that 'take charge' person she wished for. Because a Doula, who is often an experienced mother, is trained in

post partum care and breastfeeding techniques, Barbara would have received the reassurance she needed related to breastfeeding and newborn care.

I asked Barbara if her mother was able to help her. She replied,

My mother is quite a bit older. She is a little overwhelmed by a new baby, as far as taking care of the baby. She and my dad have some physical problems, so there's a limit to how much they could do.

Bruce added, "Those physical problems make them feel insecure with such a small baby" He added, 'She adopted both Barbara and her brother, so they--' Barbara chimed in, "*Her big thing was, 'I don't know. I've never taken care of a new baby, a new, new baby, so I don't know.'*"

Barbara had mentioned this fact when her family history was diagrammed She reported that she was eight weeks old when she was adopted and her brother was five months old. This is a factor that should be considered when planning post partum support. This is not to minimize the support the adoptive mother is able to provide, but rather, to understand more fully that the adoptive mother is less able to appreciate the physical recovery one experiences in the post partum period. She is unable to appreciate the physical elements that contribute to the stress and uncertainty one experiences as a first-time parent along with the added stress of learning how to breastfeed. As Barbara illustrated, her mother had never cared for a baby this young. Barbara described the help and support she did receive from her parents.

They were very helpful as far as doing shopping, coming over and doing a load of laundry, doing the dishes, and bringing the [cooked] chicken for dinner. That was very, very helpful. I still felt, even with her coming down every day, I really would have loved to have somebody living with me twenty-four hours a day. That would have made me feel the best. I felt very lonely and isolated and insecure. I really wanted somebody with me all the time.

She confided that this attitude surprised her.

I never would have anticipated that of myself. I would consider that I would have just taken things in stride. I wouldn't have a problem with it. But, I think its not that unusual.

She reported that she did receive several visits from a home visiting nurse. She described the circumstances. The hospital, where she delivered her baby, began a new program which offered one post partum visit from a visiting nurse. She stated,

Because my blood pressure was a little high, she ended up coming back a second time. That one visit was wonderful. If they didn't offer that program, and I didn't opt to get it, because it's optional, we would have had absolutely nothing. I think it's absolutely essential there should be at least one visit and in the wisdom of hindsight, there should be more.

The couple was quick to say that visits even from non- professionals would have been helpful. Bruce suggested a visit from experienced parents, "some type of cooperative service, or a volunteer service". She, however, said, "I personally feel, that at least initially, that it helps to have someone who is a professional." She qualified her comment. "Medical professional." She said,

Even as a nurse, I didn't have a nursing brain cell in my body coming home with a new baby. I was a mother, I was not a nurse. To have someone come out and reassure me that everything was okay with the baby and, because I had problems with pregnancy induced hypertension, to check me out and say I was okay. That type of thing made a big difference to me personally. I think it should be standard.

She described the second visit.

Because my blood pressure was still up she had to come back for another visit. She was just a wonderful person. Not only did she check my blood pressure she also checked the baby again. It was just very reassuring. She gave me some tips about breastfeeding. It was nice to have that second visit.

Discussion

This couple had accrued 12 indicators, requiring minimum support. They

are a good example of a well functioning, non-problematic couple who, without sufficient, comprehensive support, experienced heightened periods of stress which impacted on their ability to transition smoothly into the parenting role. Her Pregnancy Induced Hypertension (PIH) compounded the problem. It created stress for the couple before the delivery. Visits to the physician, rather than home visits, to monitor her blood pressure impacted on Bruce's work schedule which reduced the amount of time from work he was able to take after the arrival of the baby. This factor made him unavailable to provide support in the immediate post partum period. Belsky and Rovine (1984) identified three interrelated causes of stress: 1. the excessive expenditure of physical and emotional energy during labor and delivery. 2. The excessive expenditure of physical and emotional energy caring for a newborn. 3. The modification of everyday patterns of functioning. Belsky's more recent research (1994) highlights chronic fatigue and exhaustion, which were attributes manifested in this couple, as major contributors to anxiety and depression. Barbara experienced all of these stressors.

3. Misguided Support

Christine and Greg

Christine, who had described herself as obsessive/compulsive, delivered her baby a few weeks before her expected due date.

When I revisited each couple one month after the birth of the baby I reviewed the formal support options that they selected. I usually would ask the participants if they remembered their choices. Christine stated, "I remember. I think I said I didn't really need any help."

Christine stated that she had planned to stay at her mother's home for the first week post partum while Greg stayed at her apartment to feed the cats.

I asked, "Now that your baby has arrived, what would have been

helpful?"

She replied, "Not being at my mothers. They were not helpful. I didn't last a week. I think I lasted four days." She said, "Oh, it wasn't my baby, it was my mother." She stated that she would have left sooner if she wasn't so exhausted. She reported that she did not get any rest in the hospital. In addition, because she delivered her baby approximately two weeks early, the baby's room wasn't ready.

I asked her to describe what had transpired between her and her mother. Christine began.

She tried to completely take over. Every time she [the baby] cried, my mother was right behind me, tracking every step I took, every move I made. Every time I burped or fed her, my mother was leaning right over me. My father carried her up the stairs one time and almost fell. I was afraid, if I carried her down, I would fall. The entire family just got so involved. They were just leaning over me. I couldn't take it. I was going crazy.

Christine attempted to exert some control. She told them to "back off." She threatened to leave. She was detained because the baby was up the whole night. She said, "I slept all day Tuesday. I was like a walking zombie. Tuesday night I stayed. My mother took care of the baby and I just slept. That was kind of nice."

Greg reported that he didn't stay. "I knew her mother was there, constantly. She didn't need me there." He described his role as "picking up odds and ends, going over for a few hours and I'd come here [Christine's apartment] and feed the cats and then go back over for a couple hours at night and then go home."

This is an example of misguided support. The attempts from Christine's mother to support her daughter were intrusive and overpowering. This family dynamic is not new. Issues related to power and control between Christine and

her mother are striking. It sheds light on Christine's obsessive/compulsive behavior disorder. I asked Christine if her mother was able to "hear" the complaints from her perspective. She said, "She still can't." Because Christine was finishing her Baccalaureate, her mother had offered to provide child care until she finished her program in May. The struggle over control continued to be an ongoing issue.

She feels that she knows better. When mom's away, grandma is going to play. It doesn't matter what I say. She kept on saying, *'well you're the mother and I want to check this out with you.'* She'll do whatever she wants anyway.

The issue of power and control appears to be a constant theme within this family system which recurs in Christine and Greg's dyadic functioning. In the prenatal interview Greg abdicated his 'power' in the decision-making process. He resigned himself to the fact that Christine would get what she wanted, anyway. She exerted her control, knowing that his mode of functioning was to give in.

Christine threatened her mother. "I won't bring her over if I can't trust you to do what I ask you to do when I'm not around." Greg stated, "She knows right now, we only have six weeks of school, so we're stuck between a rock and a hard place."

Christine reported that the difficulties began in the hospital. She was diagnosed with Group B Strep, before she delivered her baby. She was placed on I.V. antibiotic therapy and developed an allergic reaction. The medication was stopped. Due to these circumstances the baby was sent to the NICU for I.V. antibiotic therapy immediately after her birth.

She reported that all of her family came to the hospital. Friends from school came. She said,

No one in the room was talking to me. The entire family was in the hallway, down by the nursery, by the elevators, just waiting for this child to come. They came, but it wasn't to see me.

She said,

You are null and void. You're the complete topic of conversation for nine months, then all of a sudden you have a baby and you don't exist. You've fallen off the face of the planet. Like the baby was here without you. You didn't need to be here. All of a sudden you have attention and all of a sudden you don't have attention.

She said that she expected a never-ending flow of family coming to visit once she arrived at her parent's home. She didn't anticipate the onslaught of visitors in the hospital. Once she arrived at her mother's house she established visiting hours. She said

I had to, because people wanted to see the baby, and she was sleeping. She's sleeping, she's a newborn. She needs to sleep. Everyone wanted to peek in and wanted to look at her. I wanted to sleep when she was sleeping. I didn't want to be awake.

She paused and said with resignation, "It's my family, though. They are very, very strong willed, very irritating. They do their own thing, they always have, they always will."

4. The Perception of Support

Eileen and Chris

Eileen and Chris spoke about the post partum support they received from their respective parents. On the whole, they both agreed that the assistance and support they received was helpful. Eileen's parents arrived one hour after the couple arrived home from the hospital and stayed for about five days. They anticipated their support to include, "making sure we're not overwhelmed with outside stuff." They were not disappointed. Eileen said that they did laundry, cooked, shopped, and sometimes held the baby. She stated that her mother

was very supportive informing her and helping her care for the baby. Eileen said that her mother returned without her father when the baby was two weeks old. This visit coincided with Chris returning to work. They acknowledged her help and support.

Chris, however, stated, "I have to say, I think me more than Eileen, I felt a little disappointed with my parents. First, that they waited so long to come up." [just short of four weeks after the delivery]. "Then they didn't really stay all that long." [Chris's mother came for a few weeks. His father came on the weekend]. "Especially my father really wasn't any help at all."

I asked him what "help" he envisioned. He replied,

I don't know. I hadn't thought in very concrete terms. I was expecting more of an understanding situation. I didn't know exactly how he would help out, but I thought he would appreciate that this was not an easy time for us. A time when we could use some support.

His partner attempted to highlight her father-in-law's contribution. She said, "He cooked."

Chris acknowledged this point. "He did cook. That's true. Which is something he likes to do. But, I think he would have done that even if we hadn't had a child here."

Eileen stood corrected. She replied, "Right, he cooks a lot."

I stated, "So you were looking for something more and that didn't happen." He responded, "Right."

Like many of the fathers that I interviewed in a previous study (Fraktman, 1992) Chris may have been hoping for a change in the relationship with his father. Possibly he was expecting a relationship that was more empathic and on more equal terms of father to father, now that Chris was a father. Chris's baby had been hospitalized for three days with a viral infection nine days after the birth. Chris may have been alluding to this situation when he commented on his

father's lack of appreciation for what his son and daughter-in-law had just experienced.

5. You're Going Through a Crisis

Eileen and Chris

In addition to the informal support from Eileen's parents they received one home visit from a nurse as part of their health insurance plan.

Chris stated that the visit was very helpful.

It turned out that she was concerned about his jaundice and his circumcision. She immediately had us packing to the health center after her visit. Both things turned out to be fine. I remember thinking when she came, *'O.K., you've got the job. You can stay.'* I sort of felt like, *'I wish we had someone like that around for more than just a one or two hour visit.'* She seemed very knowledgeable. Just the confidence she had that we didn't have.

Eileen said,

She showed us how to take his temperature. That was really helpful because maybe you've read or seen people explaining how, but when you have the baby right there you get hands on help that sticks with you much better.

Chris said

It turned out later that week, this is now the second week, in the middle of the night, he developed a fever. We called our HMO and they were concerned. We rushed him to the hospital where we spent the next three and a half days. He had a viral infection.

Eileen said, "It was scary." Chris said, "We were both in tears a fair amount over the three day period. I think it was one of the hardest experiences of my life."

Within the context of discussing their post delivery hospital stay this couple began to talk about their experience when their baby was hospitalized. He framed his comments around the idea that what people need in the hospital

is support, rest and people adapting to the patient's schedule. He said, "Those are the things you give up in the hospital."

He began to describe the experience. "At first we were in a room with three other cribs, so there were four altogether. It was a zoo." She added, "They weren't even all full and it was still a zoo." He continued,

The staff people would come in to watch T.V. on their breaks. Eileen, who had been breast feeding every couple of hours hadn't been getting any sleep. That is the part that made it such a hard experience. Just being thrown into this big hospital and no one really thinking about our needs as parents.

Eileen stated,

I was nine days post birth and still recovering and new at breastfeeding. At the hospital where I delivered, I got a lot of help with breastfeeding class. I talked to lactation specialists. The nurses helped me. When we took him in for the fever, I felt like people there really didn't know anything about breastfeeding. They didn't understand that I was getting engorged. He hadn't eaten in about five hours and that I needed to breastfeed him. They had their own kind of schedule. He was kind of sluggish because he was sick. He wasn't eating well. I felt like I needed to be more supported. If I wasn't going to be able to feed him then I needed to pump and express the milk. I was really uncomfortable. I was dripping all over my clothes. I didn't have any breast pads with me. I hadn't planned on staying in the hospital so I didn't really have a change of clothes.

She continued, "It seemed odd that they didn't know more about breastfeeding. There were doctors taking care of infants. The nurses didn't know much about it." He added, "It was the infant and toddler unit." She described her experience in the emergency room. She said,

Even in the emergency room they wanted me to give him some sugar water to increase his fluids so that they could catheterize him. He had just peed all over the place. They gave me a bottle of sugar water to give him. I didn't want to argue with them. They said, *'Give him a break from breastfeeding because its curdling in his stomach and he's spitting up.'*"

She reported that she was confused with that rationale. She said, "Afterwards I read more about it and that's normal, to spit up curdled milk."

She stated that she became so upset that Chris intervened. He spoke with the medical staff. He came back and said, "O.K. you can breastfeed him" She said,

heaved a sigh of relief and started feeding him. He was kind of sluggish. He wasn't taking much so they put him on an I.V. and gave him some fluids that way. In my mind it was better than giving him a bottle. I didn't want him nipple confused. The fact is that they didn't understand that, as part of our need, was a little disappointing.

The discussion continued. Chris made suggestions related to post partum support he believes new fathers need. He talked about the benefit of talking with other new fathers about the experience of becoming a parent. He then reverted back to the time when his baby was hospitalized. He said,

I remember feeling like, I am so upset and I don't really have anyone to talk to about it. I was coming home from the hospital one time late at night. They only had a bed for one parent so I would come back. I remember talking to myself. Well, if I were talking to someone else, what would I say? On the drive home I just started vocalizing what I was feeling and I started crying and crying. That felt great and was sort of what I needed. Ideally you would do that with more than just yourself. It made me realize that I could use some support, [as a new father] just sharing what I'm going through. [now, one month post partum].

6.A Stressful Beginning

Maureen and Frank

Maureen and Frank came home after a two day stay in the hospital. Maureen, who was initially ambivalent about her mother-in-law helping, stated that she was happy she had come. They reported that she arrived one week before the delivery and stayed two additional weeks. Maureen stated, "She was like a shoulder. She was company and she really met a lot of my needs so I

could meet the needs of the baby.” She gave some examples.

Like eating, especially nutritional stuff. She would constantly ask me if I needed lunch. She would make this, she would make that. That was really great. She would take the baby if I needed to lie down.

I added, “So you could have a little break or rest.” She acknowledged by saying, “Yeah, that provided a lot of mental space.”

Maureen reported that she had developed mastitis. (An inflammation in the breast, often caused by an obstructed milk duct, which manifests itself with a fever, and intense breast pain. This problem is usually treated with antibiotics. Breastfeeding is encouraged). As a result, Maureen's milk supply was diminished and her baby lost weight. Maureen described the situation. “The baby dropped a lot of weight. I got help from her pediatrician. She lost twelve ounces after we arrived home and another eight and a half.”

She reported that she was driving into the city twice a week for weight checks. I asked her to describe the pediatric visits. She said,

Kind of stressful, because it was the city and a lot of traffic. I remember the first time I went, it was stressful. She got so hysterical in the office when they were changing her, trying to weigh her and measure her that she stopped breathing in my arms. I said, *'She's not breathing'* Even though, from a nursing point of view I knew what to do, I couldn't handle it. That was stressful, definitely.

What seemed obvious (especially since I am a visiting nurse), was that this couple, rather than driving to the pediatrician's office twice a week, should have received home visits from a visiting nurse who could have monitored the baby's weight. It demonstrates the insensitivity and lack of understanding on the part of pediatrician and the staff. It is a striking example of how specialization can create fragmented care. The pediatrician specializes in the care and treatment of the baby. Understanding the needs of the parent are secondary. Weighing the baby in her own home would have been less disruptive, less

traumatic and less stressful for the entire family unit.

In the case of Eileen and Chris, their hospital experience demonstrates how a medical facility that loses sight of the family as a total unit. It is worth noting that this hospital prides itself on its Family Centered Care Model. The medical staff, specializing in the care of infants and children, appeared oblivious and/or lacked understanding about the needs of a breastfeeding mother, who was nine days post partum.

B. The Ability to Receive Help

It is important to explore one's receptivity to help when developing a support plan. If the individual does not feel worthy of receiving assistance, or believes that they do not need help, efforts to provide support will be difficult to implement.

Monica is an example.

In the prenatal interview I had asked Monica the type and duration of support she felt she would need in the immediate post partum period. She replied,

I'm kind of a pretty independent person. I have low moments when I kind of cry and I want sympathy and I want attention. I've always been independent. I probably will manage fine, myself. Sometimes I feel I don't want anybody at this stage because I've kind of gone through a lot of ups and downs on my own and I don't want the intrusion of anybody.

Monica was one of the first participants in this study. At that time I had planned to provide support to half of the study sample. She was randomly selected to receive post partum support. I called her when I received word that she had delivered her baby. I offered to come and provide support. She was receptive to my coming but viewed it as a visit rather than support.

The day was rainy and damp. It was one week after the birth of her son. She greeted me at the door. When we arrived at her apartment, two flights up,

she immediately apologized for the untidy appearance. I stated that I had come to help her. She stated, "Oh, no. I wouldn't hear of it." This response did not surprise me. Based on her interview she described herself as being excessively independent, having a poor sense of her own needs and lack of friends. During the prenatal interview I asked her what activities she did without her partner.

She replied,

I'm ashamed to say, not a lot. He's always pushing me to do a class. I mean at home [Ireland] I seem to do a lot more. I don't know. I kind of got lost when I came out here. I'm not a great mixer. I'm not a great socializer.

Monica's parents were coming from Ireland for a month. She was eagerly awaiting their arrival. She was relying on her mother to help her take care of the baby. She said,

I doubt my ability to look after a baby. I don't know what a baby needs. My mom would know. You just have little fears. I think it's just the security of somebody that knows what they're doing.

Monica's parents were expected to arrive the day after this visit. I offered to help her prepare the room they would be staying in. Again she stated, "Oh, no. I wouldn't think of it. If I had my own home with nice things, it would be different."

She began talking about taking the baby out. She asked me what I thought. I stressed that my concern about this idea had less to do with the baby and had more to do with her and the need to recover from giving birth seven days ago. Further, Monica had sustained a third degree vaginal laceration during the delivery. She reported that it was healing, but she was still quite uncomfortable. In addition, she was breastfeeding, which required rest to insure an adequate milk supply.

She confided that she had to go grocery shopping. Her husband was working, he had the car, and her parents were arriving tomorrow. I offered to do

her shopping. She accepted my offer. When I returned, she was nursing the baby. She apologized for not helping me carry the bundles up to the apartment. She instructed me to just put the frozen food in the freezer and leave the rest. I put the perishables in the refrigerator. It was evident that she had done some tidying up while I was out shopping.

Clearly, this is a woman who had great difficulty asking for help as well as accepting it. She resisted taking a nap, although she confessed that she was tired. She, however, initiated many questions related to breastfeeding, and infant care and was receptive to my suggestions.

She asked me if I would stay while she 'ran' across the street to the butcher shop. Upon her return she stated that she didn't realize how fatigued she was. It appeared that the "run" across the street may have been a reality check.

C. The Whole Picture

In order to develop a better understanding of how the issues of the couple interact and intersect with their environment and their post partum support plan it is helpful to see the whole picture. Using several case studies is an effective means to illustrate this. A genogram will follow each case study.

Case Study #1

Anita and Barry

Anita and Barry have been married five and one half of the eight years that they have been together as a couple. Anita has a family history that is heavily weighted with alcoholism, physical abuse, sexual abuse, and mental instability. Her paternal grandparents were and her two paternal uncles are alcoholics. Her father suffers from depression. Her maternal grandfather, who is deceased, physically and sexually abused her maternal uncles and aunts.

Somehow her mother was protected from this abuse. "She's only recently been able to talk to them about that, after being in therapy and putting this together as a family dynamic." All of her grandparents are deceased. Her parents married in 1963, separated in 1990 and divorced in 1994. Her parent's divorce has influenced her thinking about the importance of maintaining a relationship with her husband after the arrival of the baby. She spoke openly about her concerns related to the effect the baby's arrival would have on their relationship.

I'm curious about what it's going to do to our relationship. We've been together for nine years and married for six. He's my best friend. We've talked about still being committed to our relationship and giving that to our child as a gift, not putting it on hold like my parents did. Putting the kids first, their relationship was on the back burner and not productive. Both of our parents are divorced. We're hoping that won't get in the way.

Alcoholism is a strong factor in Barry's family. His maternal uncle and stepfather are alcoholics. His biological father, who died in a motor vehicle accident before he was born, is reported to have been an alcoholic. He has, within the past four years, begun to get acquainted with his biological father's family. Barry describes his step father as controlling who always had a can of beer in his hand. "He always wanted you to do what he wanted you to do and if you didn't, there would be consequences."

The histories, heavily laden with alcohol and abuse alerted me to the potential for maladaptive coping strategies. Maladaptive coping strategies were commonly identified in the families of the emotionally disturbed children I had worked with. Drawing a family map can initiate dialogue with the couple so they can begin to describe their coping strategies. It is an opportunity to begin to assist them in developing a strategy of enlisting post partum support. The genogram can help one visually see what potential supports might be available within the family system.

Post Partum Support Plan

Anita stated, " My mom has offered to come after two weeks, when we are home and settled." She qualified her statement by explaining that her mother lives out of state and has limited time off from her job. Her mother's scheduled arrival would coincide with Barry's return to work.

Barry reported that he has a two-week paid paternity leave that he plans to utilize. "We haven't actually talked about that. It's probably one of those things that escaped us." He wondered about support services stating, "Well, if we need it, maybe we could get some help." He planned on providing the sole support for his wife in the immediate post partum period. "I'd hope that I would be all the help that she would need." He paused and added, "We also have friends that said that if we need anything or any help, give us a call."

One Post Partum Visit

Anita and Barry left the hospital on a Thursday, twenty-four hours after she delivered her daughter. She qualified for one home visit from a visiting nurse because she elected to leave the hospital before the mandated forty-eight hours. She received a post partum home visit on Friday. Anita stated,

I didn't want her to come that soon. I really wanted her to come later than that because I was feeling like I didn't need it then. I wanted to have a few days to find out what my questions were before I had someone come out. I actually tried to make her come later. I felt it wasn't that big a deal at the time.

I asked Anita if she told the nurse that she preferred a visit in several days. She replied, "She was pushing for Friday. I didn't argue the point that much. I argued and then gave in." She continued. "I felt like Monday [5 days post partum] would have been ideal." Actually, it would have been ideal. My stitches were fine." She added, "Ironically, if she had come then she would have picked up that I was sick."

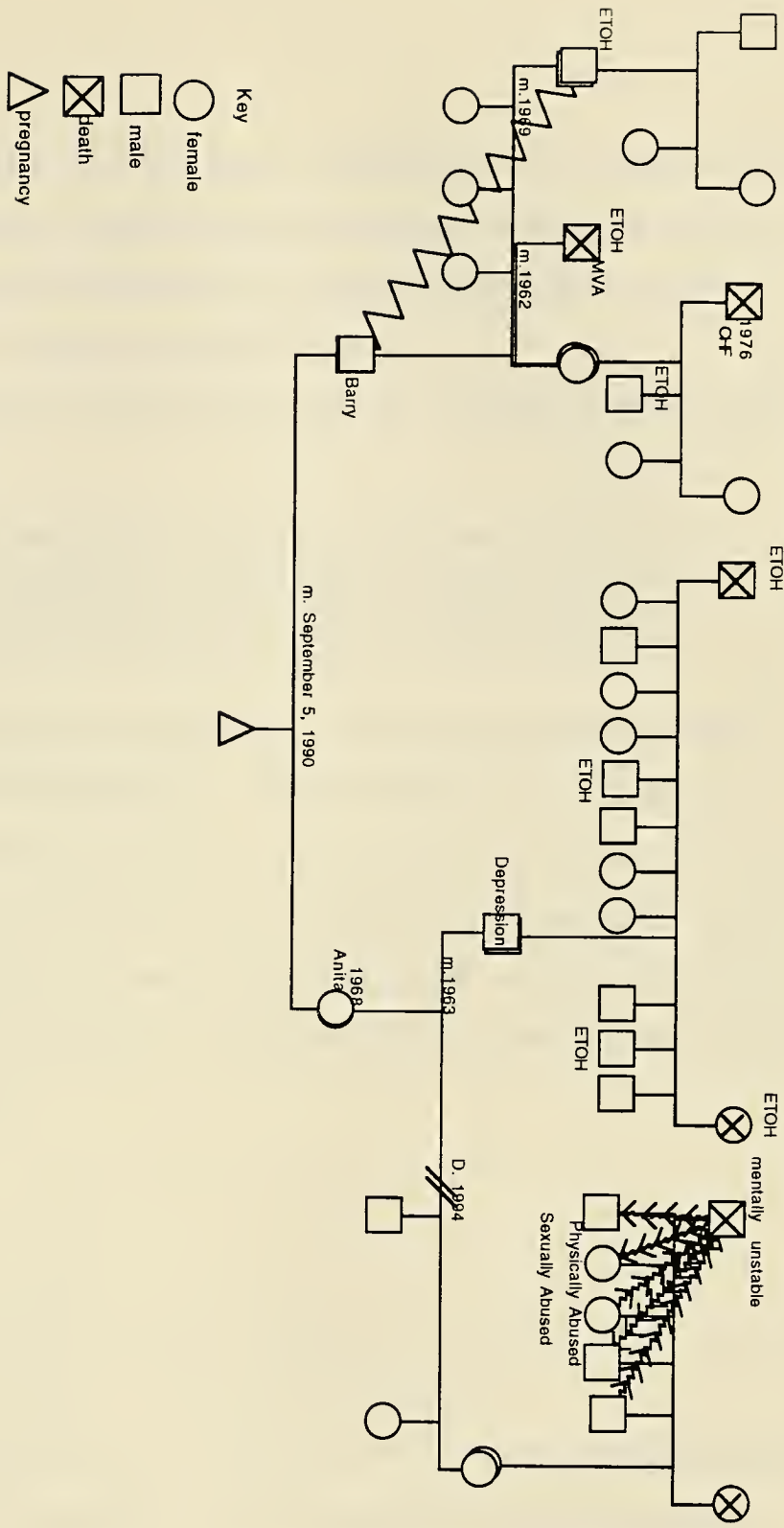
I asked Anita what questions she would have formulated by the fifth post partum day. She stated that she had more questions related to how she was feeling. She said,

I would have had more real time to breastfeed. I wish she had come after my milk had come in. That would have been more helpful to me.

Anita reported that she received a telephone call from the nurse practitioner on her ninth post partum day. Follow-up calls from the obstetrical department of Managed Care Organizations are common. Anita, who attributed her sensations of abdominal pain to breastfeeding, described them to the nurse. She stated, "We ended back in the hospital on Saturday." Anita had developed a uterine infection that had progressed to involve one fallopian tube. Anita and Bruce both lamented that if the home visit been on Monday, the uterine infection would have been detected. She would have been treated at that time which would have prevented the infection from spreading to the fallopian tube. Anita said, "Now we're at a higher risk for an ectopic pregnancy."

Anita qualified for one post partum home visit because she elected to leave the hospital twenty-four hours after her delivery. Some health care benefits state that a home visit must be made within forty-eight hours after discharge from the hospital. There is, however, a Patient Rights Clause, that states that a 'patient' has the right to refuse. In my own clinical practice some patients have requested a visit later than the 'mandated' time. It has not proven to be a problem with either the physician or the health insurance. There are several issues. The visiting nurse who scheduled the post partum home visit was inflexible. She could have delayed the visit. In the interim she could have telephoned Anita to lend support and answer any questions that may have arisen. The larger issue is the number of visits allowed. Anita's case is an example of what can happen in just a few days. Anita and Barry had accrued 13

Barry and Anita



indicators, placing them in the category of needing Minimum Support. Had this support protocol been implemented they would have qualified for one home visit the first two weeks, followed by two additional home visits every other week, totaling five weeks of post partum support.

I reminded Barry what he had selected for anticipated support options.

He said,

I think visits twice during the first week and then a visit once a week for the next two weeks would have been fine. In our situation, a whole week went by. It wasn't until the end of that first week that we began to realize that something was wrong.

When Anita was re-hospitalized her baby was hospitalized with her because she was breastfeeding. During this period of time the baby was scheduled for a check-up with the pediatrician. Barry took the baby out of the hospital and drove her there. It appeared strange that the baby, who was in a medical facility, could not have been examined there rather than being taken to the pediatrician, by Barry who was experiencing stress from this complicated post partum period.

Case Study #2

Heather and Phil

Heather and Phil have been married one of the two years that they have been together as a couple. This is a planned pregnancy.

Heather's grandparents are deceased. Her maternal grandfather suffered from alcoholism. She describes her two living maternal uncles with severe alcoholic problems. She is less clear whether her mother has a drinking problem. Her mother, however has Lupus and has suffered one stroke. Heather describes herself as the second child, but the oldest daughter. Her parents, brother and youngest sister live out of the United States. One sister lives in the

United States, about one hour away.

The genogram quickly diagrammed this woman's family and helped the interviewer determine what family support may be available to her in the immediate post partum period.

Heather reported that her mother plans to come after the baby's birth. She, however, didn't view her mother as a major source of physical support.

Her health isn't great so she can't do tons and tons. I probably would like her to come and keep me company. We haven't planned on having her here for the actual birth. I'd like the first few days at home just to be us. I think just having the two of us home with the baby for the first four or five days would be great. Then, I would like her to come for a week or two, depending on what she can do, what's going on.

Phil has no living grandparents. He is the fourth of seven children. His father, who is deceased, was an alcoholic. His brother has been a recovering alcoholic for a year. All of his family live out of state. He remarked, "It's too bad. I know some of them would like to come. We'll do a christening at some point. My mother is too old to travel much."

When I explored with him the need for post partum support he said,

Most of what I think I'm going to need is emotional support. I would imagine, if most things hold true, I think that will come from Heather. I have a fairly good circle of friends, all of whom are very excited about this [baby] for both of us.

What became clear very quickly in diagramming their genogram was the lack of a family network that would be available to this couple in the immediate post partum period. It appeared that they were relying on each other as sources of support as well as their strong circle of friends to assist them in the immediate post partum period.

Heather and Phil accrued 12 indicators on the Assessment Protocol, placing them in the category of requiring minimum support. They had little family

in the immediate area to provide support. They did have a circle of friends who were very excited about this birth.

The Benefits of Social Support

Heather and Phil were discharged from the hospital less than twenty-four hours after the delivery of their son. Heather stated,

I got a home visit from a nurse three days after I came home. It was great. She was wonderful She gave us a couple of tips that I didn't know before. A few things that were good to know.

Phil added,

It was great to have a nurse come by. I think most of the questions that we had were about feeding. That was very helpful and very reassuring. She was just great.

I asked Heather for specifics. She said,

About breastfeeding, like I didn't have to change positions every time I fed him. She confirmed that he wasn't jaundiced. It's nice to get the confirmation from an objective person. I probably would have loved another visit a day or two later because I was so engorged and my breasts were patchy red all over.

What made up for the lack of any further visits was the support she received from her friends. She stated,

My midwife friends had a shower for me on day five. I was able to show a couple of my friends, '*Does this look normal?*' They reassured me. It was nice having professional advice.

She went on to say,

I've gotten plenty of phone calls. Had a phone call, when he was one week old, from one of the nurses in the pediatrician's office, making sure everything was okay. I thought, *Great, that's a good time if anything is going on I would have said something.* My midwife called within the first week, even though I had seen her on day five [at the shower]. I kept getting phone calls from people who knew [our baby had arrived] and wanted to make sure we were doing okay. We got meals brought to us every night for a week, by our neighbors, which was great.

She then stated,

We ended up needing a tiny bit more, a different kind of support. Our house was flooded the day after we came home from the hospital. The baby was two days old and the street got flooded. It all poured down into the garage. We had four feet of water in the garage and basement. My car was totaled. Everything in the basement, except for the washer and dryer, was pretty much a loss. Phil ended up spending a lot of time cleaning out. All the neighbors came over to help us. Everybody, I mean people spent hours cleaning everything and bailing out the water with him. I stayed upstairs with the baby. If anything would have put me over the brink right away, it's stuff like that and then having to deal with people on the phone the next day, hoping someone would come and help Phil so I wouldn't feel bad about not doing anything. Crazy things like that happen that you can't predict. We were grateful to have the help from the neighbors.

This is an example of Bronfenbrenner's ecological theory at work. The couple was just beginning to adjust to life with a baby, which was compounded by an unexpected, unpredictable crisis. The incredible support they received from their friends and neighbors made the situation more tolerable. It reduced the potential level of stress so they could continue the transitioning process and adapt to this event at the same time. The support from their neighbors greatly assisted Heather who, without their help, would have felt very guilty, not being able to help her partner during this crisis.

Heather stated that her mother did not come as they had originally planned. She said,

That was my decision with Phil. Phil really wanted to be just us for a few days. She was a little upset. She comes and doesn't do a whole bunch. I didn't want to have to take care of her and the baby. I didn't want Phil to have to entertain and take care of her and the baby. We sent pictures and we're headed down to visit soon.

In the prenatal interview this couple stated that they share in the decision making process. Her remark, "That was my decision with Phil." is an example.

I asked if they felt prepared coming home with a new baby. Heather replied, "Very prepared. We both felt very prepared being home. We've known who our resources are. I know who to call if we needed anything." She added, "I think having Phil home for the ten days that he was home was a big help. I don't know how people do it alone." He said,

I didn't work the rest of the week that the baby was born, nor the whole following week. That was great. Now I only go away to work two days a week. With that amount of both of us being here it meant that Heather could nap during the day if she needed to and I could do the cleaning and cook, if we needed to.

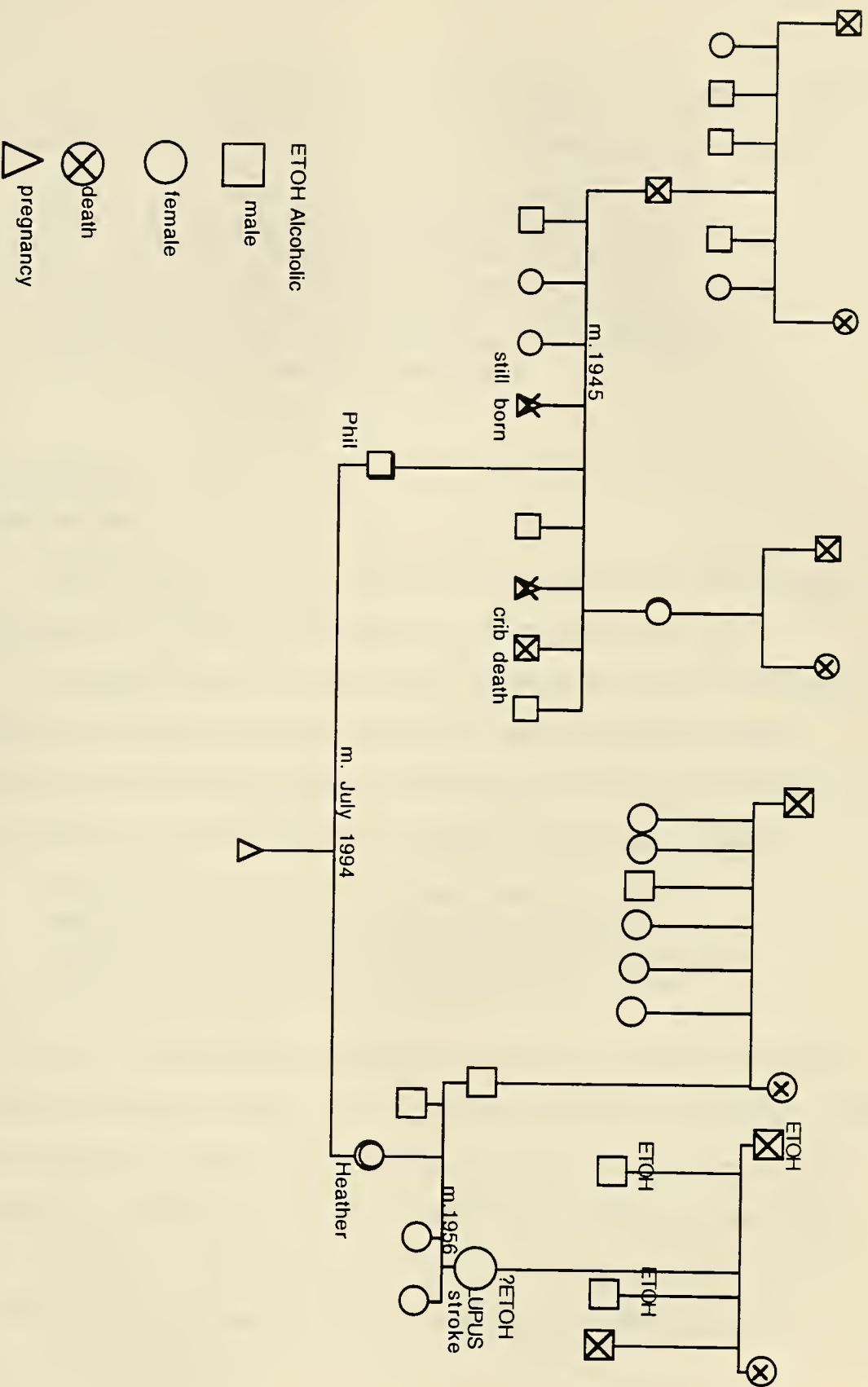
He added, "I was really glad that I was able to stay [home] so we were able to just be the three of us here, for a while. I really liked that.

I raised the issue of paid parental leave. Heather was quick to stress the importance of the effectiveness of the support one enlists. She stated,

I think it really depends on the husband or the relationship, because not every husband does as much as Phil. You can't all of a sudden expect someone to do something that they have never done before. I really think all husbands aren't necessarily the right support people. A sister, a friend, it doesn't matter who it is as long as somebody is there to help her under many circumstances.

Heather's caveat supports the research literature. This particular case dramatically demonstrates the merit of post partum support. Their support network of friends and neighbors allowed Heather to remain focused on her post partum recovery, breastfeeding and caring for her newborn. The generosity and sensitivity of their neighbors and friends reduced the level of stress for Phil as he bailed out the basement and garage and transitioned into the role of a father. They both agreed that one home visit from a professional was helpful, reassuring and informative and a second visit was not necessary. Phil said, "It certainly would have been pleasant to have somebody stop by officially again, but it wasn't necessary."

Phil and Heather



They both exuded a sense of confidence about themselves as parents.

They both were enraptured with their baby. Phil summed up his experience.

I had no idea what to expect. I didn't expect that I would have so much fun sitting at five thirty in the morning just watching the baby for an hour. Not caring for him, just looking at him. Vast hours; a vast amount of a day can disappear and you realize that you have done nothing but look or kiss his head or play with his fingers. I'm surprised how much of that there is and we enjoy.

Case Study #3

Sylvia and Don

Sylvia and Don have been married four of the six years that they have been together as a couple. Sylvia had a miscarriage one year ago.

Don's parents were married in 1954. His brother was born in 1959 and he was born in 1961. His parents divorced in 1964. Either parent did not remarry This is the first grandchild. Don voiced many concerns related to the impact their baby's arrival might have on their relationship as a couple.

We've seen the degree of strain that it puts on people's relationships. How the intimacy is sort of transferred between parent and child, not between parent. The fear, at that point, was we hope we can cope better than some parents we've seen.

Sylvia's parents married in 1963. She was born in 1966 and her sister was born in 1968. Her parents divorced in 1970. Her mother remarried in 1976 and her father remarried in 1980. She states that she is much closer to her mother than her stepmother. Her father died in 1992. She had a miscarriage in 1994. This baby is the first grandchild in the family. She talked about avoiding 'pitfalls' regarding her relationship with her husband after the birth of their baby. I asked her to elaborate.

Oh, couples who never spend any time with each other. Their relationships seem to have suffered for parenting. They don't seem to have much energy or passion for each other. They don't even know each other very well any more.

Sylvia described one couple they know who irritate each other. She believed that the source of irritation was related to the woman's attachment to her baby. She reported that they struggle over the where the baby will sleep, either between them in their bed or in its own crib.

Things like that, seem like avoidable problems if people communicate better or had more priorities in terms of a couple. That's something that we worry about a little bit, because we're so happy together as a twosome.

The genogram lends insight into this couples' concern over the potential demise of their relationship. They appear to have actively and openly communicated their concerns in an apparent effort not to repeat their family history. It is interesting, however, that neither one, during the interview, appeared to connect their preoccupation with maintaining their relationship as a couple to their own experience of being a child of divorced parents.

Sylvia and Don deliberated over which family members should come after she had the baby and when they should arrive. What compounded their dilemma was the configuration of the couple's family system. Sylvia's mother and step-father and Don's divorced mother and father all planned to come immediately after the arrival of the baby. Don said,

We've gone back and forth on whether or not we want parents to be allowed to enter the territory within the first forty-eight hours. The first impulse was not to deal with it. The second one was, if we don't deal with it, they'll be in our living room before we get home. Now, just the sheer excitement of having the child and knowing that they will only be here for so long and we'll have the kid for so much longer, we're leaning toward having people come right away. That would mean that there would be a lot of people which we would have to negotiate.

What this couple does not discuss is the type of support these family

members will provide. The couple seemed ambivalent over the timing of the arrival of their parents. They appeared unclear about the ways in which the family members could or would provide help/support. The expected due date was very close to Thanksgiving, which contributed to their dilemma.

How much is Enough Family Support?

They arrived home from the hospital to be greeted by family which they described as, "a mixed blessing." Sylvia stated, "They were very helpful, but, it was hard not to have any privacy. It was emotionally draining." She identified the family members.

My mom was here, my step mom was here, my step father was here. Don's dad was here and his mom was here. We had so much family. It was nice. We got meals, the house was cleaned, but there were too many people at times.

I reviewed the fact that during the prenatal interview there was deliberation about whether all the family members should come immediately after the baby was born. When they decided that they would let them come they had anticipated some of the chaos and activity. I asked what would have been helpful. Don responded,

It would have been helpful if they all would get along better. But, that's the nature of families. It would have been more helpful if we had more time to ourselves. I think we both felt that for two weeks we were entertaining at the same time they were trying to help. But, they were still in *our* house. In some way, the couple of days in the hospital by ourselves was more relaxing and fun with him than it was when we got home.

This is an example of a "too many cooks spoil the broth" phenomenon. This couple had accrued 15 indicators qualifying them for Minimum Support. The prenatal assessment interview would have been the appropriate time to help the couple develop a post partum support plan. They could have been guided to include all the family members, but in a manner that would be realistic

in order to maximize their help. Because of the family dynamics, this couple was not able to adequately set realistic limits with them. Not knowing, as first-time parents, what one needs in the immediate post partum period contributed to the problem.

1. What's Normal?

Don declared, "There were two separate issues: family verses getting help, I mean having professional help."

Both he and Sylvia stated that they had numerous questions that they wanted the doctor to answer. I asked for examples. Don responded, "Questions about his tear duct, which wasn't working properly." Sylvia added, "You don't know what's normal." Don repeated, "Yeah, what's normal?. How to take care of it." Sylvia continued, "And sleeping. Do we wake him up to feed him or do we not? I had breastfeeding questions." Don said, "He was breathing really heavy when he was sleeping. We worried was he having trouble breathing or is that the kind of way a newborn breathes?" Sylvia said she asked, "Was everything normal?" Don repeated her question. She replied, "But how did we know?" Don said, "We'd be leaning over the bed looking at him to make sure he was okay."

Sylvia, who had worried about having her mother, who was non-supportive about breast feeding, added,

And I did need breastfeeding support. My mom ended up being more neutral than oppositional, but she certainly wasn't a supportive person. I think I sort of changed her to neutrality at least.

I asked her how she did that. She responded,

I was so aggressively saying to her, *You have to support me.* that I think she realized that I was seeing her as someone very unsupportive. I think that sort of embarrassed her, that her daughter would see her as someone unsupportive, that she tried to be more supportive. And she was.

2. You Need a Network of Support

As the discussion about support continued, Don shared his point of view.

There were so many issues, do we wake him up when he is sleeping? We got into these developmental issues really quickly. At first I thought that there would be some definitive answers. I thought daily phone calls would be helpful in that regard. But, the more I talked to people, sought out advice by calling somebody or looking at books it became clear that there's no real clear answer. Having one person call me on daily basis is kind of ridiculous. If that one person thinks a pacifier is okay and the pediatrician says something else, it depends on who, in fact you're talking with. So it's useful to get support from a variety of people and just feel as if you have a network.

Sylvia described how she developed a support network to help with her breastfeeding needs.

Some people offered their assistance and I called them. I called people, a child birth educator, whose classes we had taken. I called her a few times. I rented a breast pump from a woman and I called her several times. I called a friend who lives right across the street. I think people need help [with breastfeeding]. It's something that , as natural as it is, it can be sort of complicated.

To illustrate Sylvia's ego development and her ability to problem-solve examples from the prenatal assessment interview follow. I asked her to describe herself. Sylvia stated,

I think I have a good sense of humor. I'm fairly smart, and intense, a little intense emotionally and intellectually at times, but not too much, hopefully. Sometimes I think I'm too selfless and don't take myself seriously enough as a person and an individual, but other times I'm selfish and sort of not generous about things like my time.

She confided that she had a low stress threshold, which she felt had worsened during the pregnancy. She stated that she was easily overwhelmed. I asked how she manages these overwhelmed states. She replied,

I get upset. I don't cry. I may have a little temper tantrum, which I usually take out on Don since he's around me the most of anyone. I just try and organize my psyche, and organize my life a little bit. I just think about what I really need to do. I make a list and sort of try to dump my anxieties onto the paper, try and settle them and organize in a rational way. I just get organized in my head.

These descriptions, expressed during the assessment interview, help to illuminate Sylvia's level of confidence in her ability to take charge when she is overwhelmed and under stress. It demonstrates how she was able to organize a support network to help her with her breastfeeding needs.

Sylvia reported that she has organized a mother's group that had just met for the first time the day before our post partum interview. I asked her from where she solicited the mothers. She replied,

We met at the [Childbirth] classes. Two from the child birth classes, a neighbor, and her friend, who she met from work. It's sort of an eclectic group. We have a total of five women in all. They all brought their babies. It's great support. We're going to go to different houses every week, so we started here.

She said that the babies ranged in age from twelve weeks to her baby, who was four weeks. She stated,

So we found support in different places and turned to different people for different things. Like Don was saying, there are so many things that don't have clear cut answers. Hearing different answers from everybody we are able to put it together for ourselves.

Don added, "And saying what we are most comfortable with and what makes more sense to us." Sylvia sighed, "It's been pretty good. I think we've had a good month" Don sighed, "You bet!"

This narrative supports Vaux's (1988) recommendation for an ecological support system. Sylvia and Don's strategy of exploring all the avenues and then coming to a decision supports the premise that parenting is not a skill you learn. It is a relationship that is developed over time. It is taking in information,

applying it to the situation, assessing it, embracing what makes sense and abandoning what doesn't.

It Takes Teamwork

I asked Don and Sylvia how they managed their fatigue. Sylvia replied,

Well, he's [the baby] a pretty good sleeper. We've worked out a pretty good system. He goes to bed about eleven, wakes up at three or four and I feed him. It takes about an hour. Don gives him a bottle in the morning, at about seven, when he wakes up again. I keep sleeping until eight thirty. I get up and pump milk for a bottle for the next day, because the baby has gone back to sleep.

Don added, "So I get about six and a half to seven hours straight and then Sylvia gets about eight and a half with an hour interruption."

I asked them how they arrived at this arrangement.

Sylvia stated, "I think I was really tired one day. We hadn't done bottles.

Don said that he would try to give him a bottle in the morning so I could sleep."

Don added,

And it really seemed to make sense. In the beginning, when he was sleeping in our room, I'd get up and talk to Sylvia while she nursed him, because I'm a light sleeper, I'd hear him nursing. Once we moved him out of the room, I slept through. I was getting enough sleep.

He qualified his comments.

I don't know if it would work as well for everyone. I'm in a situation working out of my home as a doctoral student that I've got a little more time in the morning than the average person who has to get up and commute to work. I can take him from seven to nine, pass him off and be at my desk.

Sylvia continued.

It works pretty well. Since Don is here, even when the baby's asleep, I can go out. I can get stuff done and Don can get his work done. The baby is sleeping. Someone just has to be here, it doesn't absolutely have to be caring for him.

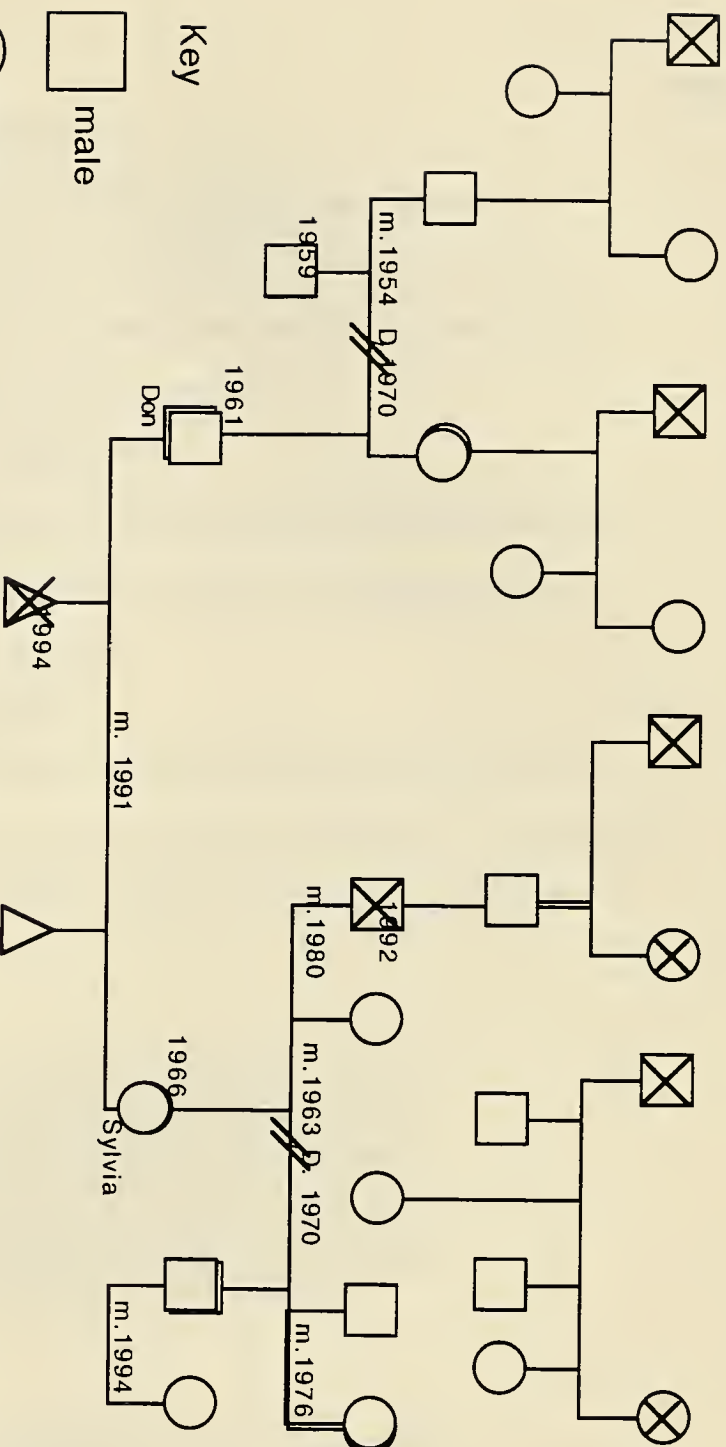
This case is a good example of the point Cowan and Coie (1987) make,

based on their research. They stress that a 'new person' in the house is disequilibrating, which initiates a process of catching your balance. This re-organization process requires both energy and active problem solving. Throughout the interview with Sylvia and Don, the on-going re-organization process they employed is very apparent.

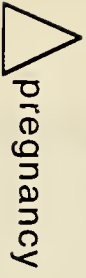
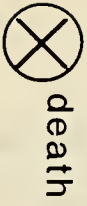
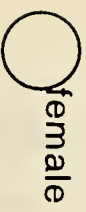
The fact that Don and Phil were home with some flexible schedules minimized the isolation and the all consuming task of parenting that many of the other participants experienced. This factor is significant when considering the implementation of paid parental leave and the benefit it provides. Both Don and Sylvia and Heather and Phil demonstrated how they worked together as a team. They demonstrated that their availability, their active problem-solving strategies, how they functioned as a couple, and their extensive social support network all contributed to a smoother transition into the parenting role.

When I commented that it seemed like a fairly smooth transition, Sylvia responded, "Yeah, as smooth as a totally life transforming transition can be!"

Don and Sylvia



Key



D. divorced

m. married

Section V The Post Partum Time Line

Meeting the couples one month after the birth of their baby was invaluable. The post partum experience was still fresh in their minds. What emerged from these interviews was information that began to define both a physiological and psychological post partum time line .

Week One

Comments from the couples regarding their first week post partum were strikingly similar. One of the first critical points that many identified was the transition process from the hospital to home.

1. The Transition From Hospital to Home

Sonia said, "Coming home with a new baby, even with support, was harder than I expected." She continued, "It was scary, really scary. I was terrified to leave the hospital. I didn't know what the heck I was doing, even though I should know."

I asked her to elaborate.

I was just anxious that she wasn't getting enough or that I wasn't doing it right. I worried about whether I should wake her or let her sleep. That was the hardest part. I worried about going to sleep at night. What if she didn't wake me up? It's different in the hospital because you don't sleep so soundly. They come in and wake you up all the time. I was kind of surprised that I was so scared to come home.

Bernice stated,

Leaving the hospital was overwhelming. I had a C-Section. I couldn't do anything. I had a little post partum [blues] the first week. I had no clue. It was really overwhelming, extremely overwhelming. Somebody should have told me more.

I asked, "Like what?"

She replied, That you're going to have to experience these feelings of doubt and unhappiness. No one told me how bad it was going to be the first week. I didn't know how to take care of him. They don't prepare you for after the birth.

I asked her to elaborate on her feelings of doubt. She answered.

Doubt, like I made a mistake. There goes my life, my old life. I made a mistake having this baby. I felt all those things. I don't have those feelings anymore. It was such an overwhelming thing for me.

She continued.

It's just incredible when you're first-time parents. You don't realize. You don't think about it [when you are pregnant]. Then, when he comes, you realize, *Oh my God, things are never going to be the way they were.* It's a shock to the system.

Jim stated, "We were so frazzled. The first night was the most stressful. The baby was constantly crying. We had to adjust to his crying. We were so exhausted!"

Maureen said leaving the hospital was both good and overwhelming.

I remember walking out and going down the stairs and seeing all the crowds of people. It was just like her first step, an introduction to the world. I thought, *Oh my gosh, she's so tiny and so frail and vulnerable. This is the world and everyone is huge and she's our responsibility.* I cried. I cried all the way home in the car.

Chris spoke of their hospital experience after the delivery as not good. Eileen added, "fragmented care." Chris continued. "In a way it was kind of disorganized in the way a big institution might be." He gave an example.

For instance, we might finally be getting a break from him feeding and we'd just start lying down because we hadn't gotten any sleep when in walks someone else. There was no schedule as to when things would occur. There was no flexibility to adjust to our schedule. It seemed like we didn't get any rest the whole time we were there.

In spite of the criticism both agreed that they would not have elected to leave twenty-four hours after delivery. Eileen stated, "Even though it was disruptive I felt comforted knowing that we were there and people there could help us." Chris added,

The funny thing for me was I didn't want to leave because I didn't feel confident about taking him home, just us being alone. We felt very supported by all the staff.

He confided, "Once we got home I felt like, *Oh! this is so much more restful.*

Monica stated,

It was a very stressful day when we came home. It was a shock for me and a shock for the baby. He wouldn't feed. He was getting very fussy. My breasts were really full, a surprise for me, and it took him a while to feed.

I asked them to describe the stressful aspect of their experience.

Monica said, "We were both very tense". Gerald added, "Tired."

Monica continued, "Tense with each other; tired and tense and maybe the expectations. I don't know what we expected. We were kind of tense with each other." She added, "The next day was lovely, it was much more relaxing."

2. We Had Each Other

Carla said,

I was scared, initially. Then I thought, *O.K. get over it.. We're not baby-sitting.* James stayed out of work for the first two weeks so that was helpful, just to work together, to figure it out together, 'cause it was scary.

I asked her what the scary part was. She replied. "The whole thing."

She continued. "Hoping that I did everything, just learning different things."

3. Post partum Doesn't Last Forever

Sally and Jim

Sally had an unplanned home delivery. After the delivery she spent two days in the hospital. In the prenatal interview, Jim worried about his level of functioning when he expected to be sleep-deprived. Jim said,

I was thinking that what I would have liked more than anything else was not only the preparation for the labor, which we had, but also some kind of preparation for when you become a parent. Like when you come home, it's totally different. Your life is totally changed.

Sally stated, "I had such a thing with the blues when I got home." [from the hospital] I asked her to elaborate.

It was great at the hospital and even the first couple days that we were home. It was just so miraculous and wonderful. We were just in awe. We absolutely adored him. Then the blues came crashing in on me within four days afterward. Just gray. I got that gray feeling. It was frustrating because I couldn't go outside. I couldn't walk up and down the stairs because I would start bleeding. I started getting cabin fever, which contributed to it. I just got panicky and overwhelmed. Part of it was that it was so difficult. The birth was so easy. [She had an unplanned home delivery] The coming home process [from the hospital] was the hardest.

During the prenatal interview Sally spoke of experiencing episodes that she described as "Blue periods." She stated that her sisters had suffered from various degrees of post partum depression. She added that she has an aunt and a cousin who suffer from depression. "I would say that it sort of runs in the family." This information, gleaned in the prenatal assessment interview, would have been helpful in responding to Sally's needs when she spoke with the midwives over the phone. Sally's planned support from her mother fell through, causing her a deep sense of disappointment. At the time she was experiencing this 'cabin fever' the area was blanketed with several feet of snow. She attempted to clarify the experience. She said, "All of this is much more on a psychological level than anything. Within ten days this feeling sort of cleared up." Sally identified her sources of support.

Talking to the midwives was great. I called a therapist. I had a couple of sessions with her over the phone, which was really nice. I had a friend of mine come over and give us massages, which was also very nice. We were able to access various kinds of help.

In the research study conducted in China by Chen-Ch (1994) four indicators for post partum depression were identified. Sally possessed three: 1. lack of social support, (in the immediate post partum period) 2. perceived stress and 3. an unplanned pregnancy.

It is unclear why a plan for home visits was not implemented at the onset of her depression. It is an example of our medical system that focuses on responding to a crisis rather than averting one. Who determines the level and/or duration of the crisis is the question that is puzzling. Luckily, Sally responded to telephone therapy, and the support of her partner, family and friends. At what cost, is the deeper question.

This couple had accrued 21 indicators, requiring Moderate Support. The design for that level of support included one home visit for the first three weeks followed by a home visit every other week for two weeks, totaling seven weeks. A visiting schedule, such as this, could have averted this woman's depression.

Sally stated,

I found the midwife visit helpful. I would have gone for a weekly visit for the first couple of weeks. I liked the one a few days after. I would have gone for even a couple more visits within the first two week period. There's a certain kind of help you need.

She spoke about the need for reassurance.

I had such confidence in my body in terms of the actual labor and delivery. That was absolutely true. I just knew everything would be fine, that your body was doing what it was supposed to do. Being confident as a mother is something totally different. I think that I have a fair amount of confidence compared to a lot of people, but I still needed a lot more reassurance. I needed reassurance that my post partum blues would go away, that my stitches would heal and the bleeding would stop. I really needed that feedback, especially from people who are in charge. It feels really good to be talking to a nurse midwife or the pediatrician. It makes a lot of difference.

She said that she talked with her sisters during this time. One of her

sisters reassured her by saying, "Post partum doesn't last forever." She stated, "I needed to hear that a lot. I needed to think that way in my head."

4. Overwhelming Exhaustion

Couples talked of the exhaustion, both physically and emotionally. They had not anticipated that each of them would be so exhausted from the experience of labor and delivery. They had under-estimated the level of fatigue their partner would experience. The perceived expectation that the partner would be available to provide support in the immediate post partum period, both physically and emotionally, was not always realized. His level of exhaustion impacted on his availability.

Heather stated, "I think we don't think as much about husbands being tired too. Everyone focuses on the woman being tired because she gets up every hour."

Christine stated that she has gained a different perspective now that she had become a parent. She described her lack of understanding when mothers would say, "I can't, I have a baby." She stated, "When the baby is sleeping, you're passed out on the couch. I never realized how tired it is possible to be."

Many of the women talked about the physical recovery in the first week. They were surprised, that even after four days post partum, they still experienced soreness, stiffness, and fatigue.

Monica said,

For the first week, you're really a patient yourself. You have a lot of looking after yourself to do, that you haven't even perceived. You're sore and everything is painful.

Week Two

1. We're Still Adjusting

As the couples shared their experiences a slight change could be detected in their comments. The subtle shift was a reduction in the intensity as

they described their adjustment to parenthood. They all agreed that life had definitely changed. For some that realization was more dramatic than for others.

Frank said,

By the second week I realized that my lifestyle could not continue. I was playing on two sports teams. It actually took some friends of mine to give me some advice. That really helped a lot.

Maureen stated that a busy schedule of going out to dinner one night with the baby, attending a church function, "and doing other things" had caught up with her by week two. She said, "It really hit me the second week. I was exhausted!"

Chris stated that he continued to feel underconfident.

Others stated that their initial fears began to subside. They came to realize that the infant was less fragile than they had first imagined.

Often, two weeks after leaving the hospital marks the period of time the baby goes to the pediatrician for the first check up . Some of the couples actually brought the baby in the first week. Most of them felt reassured that the baby had gained weight and the professional told them that the baby was fine. Others experienced the pediatric visit as an additional stress.

Laurie, originally from Canada, described her experience. She said,

"I delivered the baby on Thursday, came home from the hospital on Saturday and Monday morning I was on my own." Her husband, Mark, went to work. She went on, "I took the baby to the pediatric check-up on Tuesday." She said, "Thank heavens I didn't have a C-Section because Mark was working." She stated that she drove to the pediatrician's office. "I hadn't driven for a couple of weeks, so I was driving slow and concentrating." She said that the baby car seat added to her stress level. "You can't see the baby because he faces the back of the seat. It was an experience."

Laurie told me that the reason for this pediatric appointment was to accommodate the physician. She stated that he did not have 'visiting' privileges at the hospital where she delivered. He had not seen her baby and therefore scheduled this appointment.

Monica described the visit to the pediatrician as reassuring, but stressful.

She said, "It was his first day out. He was almost a week."

Gerald stated,

It was awful; it was stressful. I was very conscious of how vulnerable he is. We were in the hospital and there were a lot of young children running around. I was worried about infection. Taking him out in the car, bringing him out. It was cold.

He added,

I missed a day's work. I was under a lot of pressure at that time. When the baby was born I missed three days of work. I was trying to beat a deadline.

These two examples highlight the fragmented system of medical care. It demonstrates the lack of understanding by health care professionals who are so focused into their specialty. It again addresses the lack of emphasis that is placed on the post partum recovery process.

All the couples continued to experience different levels of fatigue. Their lives, now with the baby, had changed, but had begun to normalize. The couples were beginning to come through the fog.

Sylvia reported. "It took me two weeks to stop bleeding." What she hadn't been taught by the health care professionals was that her excessive activity prolonged the bleeding. Since she did not receive a home visit and was scheduled for a post partum visit in six weeks, she did not understand her need to rest.

Christine said, "We eat in shifts." She stated that before the baby's arrival,

"We used to have dinner exactly at six o'clock. Now we're lucky if one of us gets a salad by six."

Week Three

Life Continues to Normalize

The couples continued to describe periods of feeling tired. Many of the women reported that they began to feel physically better, especially those who had Cesarean deliveries.

Bruce summed it up nicely. It was towards the end of the third week that we were finally figuring out how to be parents. You're becoming a little calmer

Barbara continued, "The post partum is beginning to end. From my perspective, I'm more comfortable with the baby. You're regaining the capacity to think." Bruce added, "And regaining some control" The big thing that was overwhelming was, *My God, this baby is it..* " Barbara continued,

Yeah! The baby's here, your life is completely changed and it really hits home when the baby comes home. You realize then how much your relationship with your husband has changed. Your relationship with those around you has changed. You realize that the baby, for the most part, has total control as far as scheduling and you're just kind of running around trying to keep this baby happy and satisfied and you're not quite sure how to do it. It's just everything lumped together. It's all of it, plus the post partum depression.

Barbara reported that she cried for the first three weeks post partum.

Barry, who had two weeks of paid parental leave, talked of the difficulty he had returning to work. He described how hard it was for him to leave to go to work. Once he was at work, he stated that it was hard to get motivated to do the work.

Eileen and Chris discussed a phenomenon similar to one that Ben experienced. Eileen said,

I think it's hard for Chris because often when he gets home from work it's when the baby starts to fuss. I think that's a problem for the dads who are working while the mothers are home all day. I get to see the baby in all sorts of different moods. Chris gets to see him fuss every night.

Linda was a happy mom if she wasn't breastfeeding. Her husband, Ben, stated that he felt more experienced with a baby in the house because he has a sister thirteen years younger. He did identify one thing that surprised him. He said, "He's not as happy as I'd like him to be." Linda added, "His cranky time is in the early evening right when Ben comes home." She added that now "He's just starting to be nice. I mean not crying constantly."

Week Four

Getting Back into the Mainstream Again

Although the fatigue lingered for most, especially the women, their description of moving toward the mainstream began. They started to describe their lives, although still not normalized, in a more optimistic light. They all appeared more confident in the belief that they were moving in the right direction. The women, in particular, either alone with the baby or with their partner began to return to the mainstream.

Bernice, who had a Cesarean delivery stated, "I started driving, again."

Maureen proudly stated that she and Frank were having friends in for a meal for the first time.

Sylvia announced, "I'm wearing my regular old clothes, normal kind of wardrobe instead of pregnancy wardrobe, which is really nice."

Monica and Gerald spoke of getting ready for a transition. She was returning to work and he would be the primary caretaker. He spoke of the post partum experience as a series of transitions. He began. "We're in a state of flux rather than on a plane. It exists for an hour and then, it's moving, and we have to

adapt to the tune of it.” He continued, “You have to take just one day at a time. You do the best that you can do on that day and see if it works. If it doesn't work, you try something else.”

Christine announced that by week four she and her partner were eating together more regularly. She proclaimed, “Dessert doesn't happen until nine, if it does, assuming we're still awake.” She then added, “We compensate. We're doing it. It's tough, but we're doing it!”

Mark, who was guarded during the prenatal interview attempted to put life with his baby into perspective. He began,

Right now, there's no gratitude. There's nothing. There's no Da-Da when you come home, there's waa ,waa! The biggest adjustment is figuring out that you don't have any time for anything you want to do, right now. It just stops. It is almost like a car accident, it's that abrupt. Even when somebody tells you it's going to happen, not until it actually occurs, do you realize what the impact is like.

I interjected, “ It's an all consuming kind of experience.” He agreed and continued,

You can't do anything without his getting first consideration. We used to go to the movies at will. It just stops. There is no such thing as random. It's monumental. I could write and put a new software program on the market before we could figure out when would be the best time for us to get a babysitter so we could go to a movie and dinner. Maybe it's something that will grow with us.

What became apparent as the participants described their experiences was their progressive recovery. Many were surprised by their reaction.

Sally said,

I came to the realization that you are doing something for twenty-four hours a day, seven days a week for twenty years. You never stop being a mom, ever! I think that was really scary for me.

Chris spoke about needing a forum to share experiences with other new parents. He said,

Being able to talk with people about the experience, not just the *Oh isn't it wonderful* part of it, but the insecurity and the underconfidence--like the feelings of anger and frustration Just to be talking about what I'm going through. It's a major life change, but in many respects [you] treat your life as if everything is normal, like at work. I could use some support, just sharing what I'm going through.

He added,

I don't think feel like we've gone through a horrible catastrophe. I really feel wonderful about the events of the last four weeks. In many respects it does feel great. I don't feel like I'm traumatized or my life has been ruined. I feel really good, but it still is a huge transformation.

What Chris and most of the participants conveyed is the evolving process they experienced as they assumed the parenting role. Over time they expressed more confidence as parents. They were aware they were charting new waters which contributed to their inability to feel completely relaxed. They were beginning to see more responsive smiles from their infants. What was evident was the relationship that was developing between each parent with his/her infant.

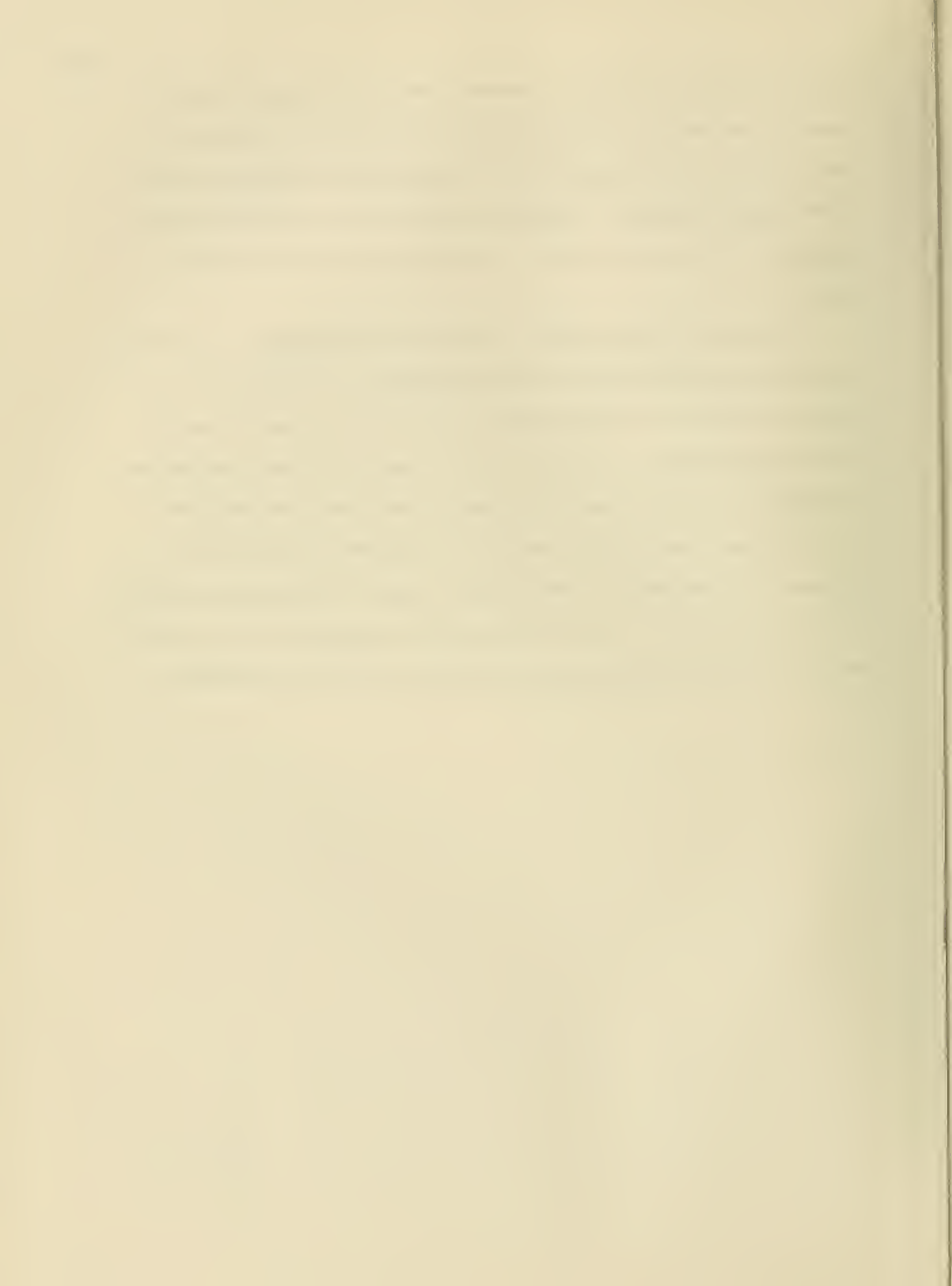
Implications for Support

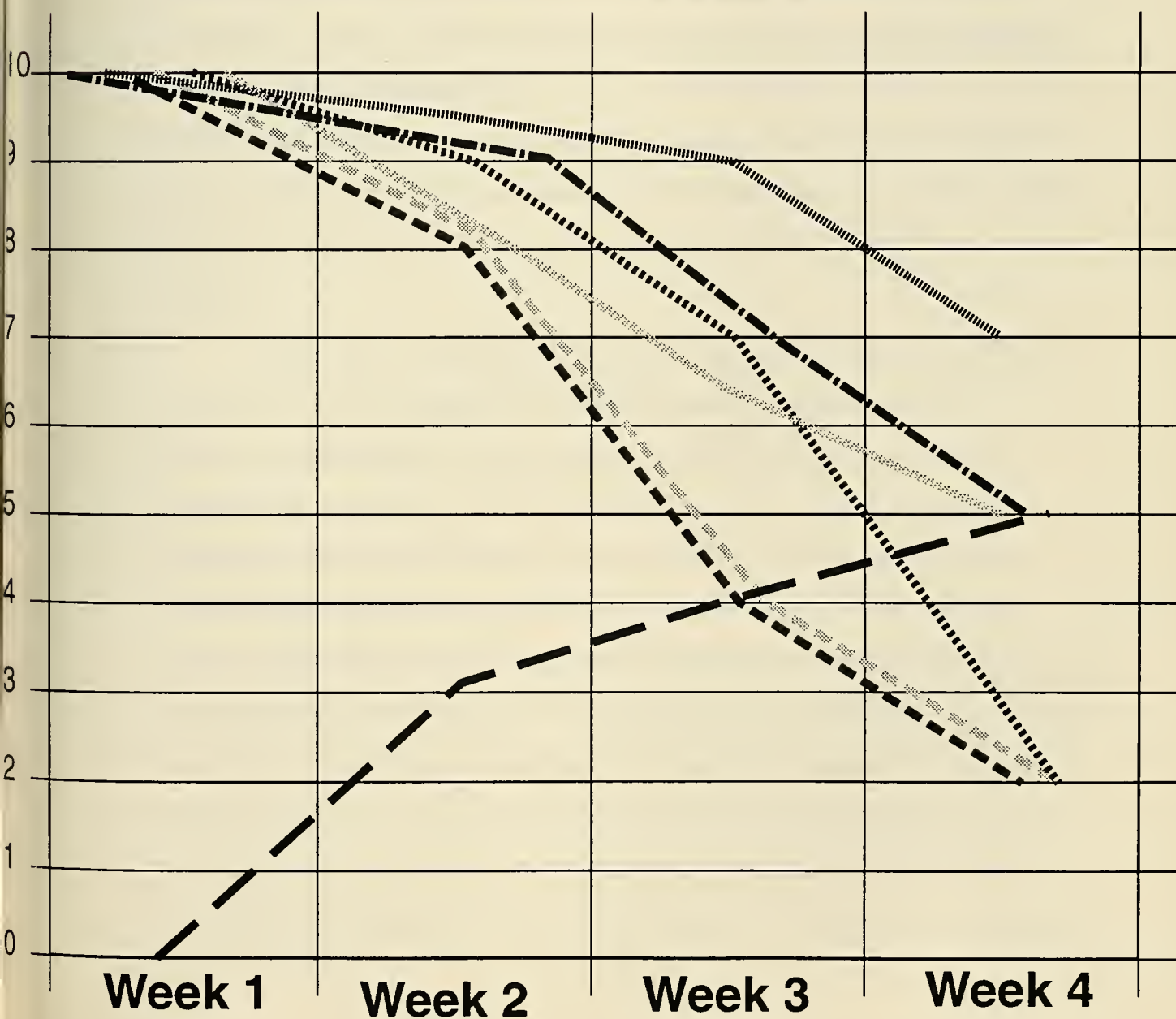
The descriptions shared by the couples vividly illustrate the physical and emotional post partum recovery process. Weeks one and two appear to be the most critical time period that warrants both formal and informal post partum support. This formulation supports the research of Crnic and Greenberg (1987) who stress the importance of providing support in the early phase of the post partum recovery. Barry's suggestion that a professional visit twice in the first week seems realistic. A combination of professional visits and telephone calls, especially during the first two weeks, that supplements an informal support plan address the physical and psychological needs of the new parents.

It is important to validate the feelings that individuals experience during

this time of transition. Gerald's comments regarding his life being a series of transitions and Mark's comments regarding the thankless task of caring for a newborn are both supported by Rose's research (1989). New parents need to know that their feelings are not peculiar to them, but are experienced by most new parents. They, like Sally, need to know that post partum doesn't last forever.

The following page contains a graph which has attempted to capture the post partum experience that the participants described. It is important to note that both individuals in the immediate post partum period appear to share the same degree of anxiety and exhaustion which gradually declines over the next few weeks. More often the women, especially those home alone after their partner's return to work, begin to describe some degree of isolation which increases as the support from extended family wanes. This information with its visual impact continues to validate the need for a comprehensive support plan that should be implemented in the immediate and early post partum period.





Chapter V

Conclusion

During the last century the way pregnancy and child birth are viewed in our society has undergone dramatic changes. Politics, policies and technology have all contributed to this transformation. These events have evolved from a natural process that was primarily attended by women to ones that are scrutinized by high technology and constant surveillance. What has been conspicuously absent, especially in the latter half of this century, is the attention directed toward the post partum period. Almost twenty years ago, research, pioneered by Cowen and Coie (1978) identified that new parents, especially first-time parents, exhibit a range of emotions that include anxiety and stress as they transition into the parenting role. Subsequent research has consistently found that social support ameliorates stress and facilitates a smoother transition for new parents. The results from this research study concur with these previous findings.

This study has dispelled what has been characterized as the myths of motherhood. The assumption that providing post partum support is not necessary, (especially for intact couples), has been challenged. It clearly conveys that parenting is not an instinct, but rather an intimate, evolving, demanding relationship between parent and infant. The participants in this research project described the hard work and the range of emotions from anxiety to exhilaration they experienced as they assumed the parenting role. All the participants agreed that parenthood has affected their identity and reshaped their dyadic relationship. Bronfenbrenner's theoretical framework, employed for this study, proved to be an accurate model. The participants demonstrated that their experiences are not isolated but rather are embedded in the context of their relationships, and their environment, which have colored and shaped their

ease in the transition into parenting.

Throughout these pages these first-time parents have given voice to their experiences of pregnancy, birth and post partum recovery. They shared their personal stories with the hope of informing others who will travel the same path.

The Assessment Interview has captured the range of emotions and expectations of the participants. Their words have described the tensions, the anxiety, the disappointments as well as the love affair they have with their new baby. The importance of timing the first interview in the third trimester of the pregnancy proved to be consistent with the research. At this time the couples had begun to develop some concept of life with a baby. This factor made them more receptive to consider the idea of post partum support. In fact, all of the participants had made some arrangements for informal post partum support. The prenatal interview provided an opportunity to introduce the idea of developing a comprehensive post partum support plan. Esther, who did not complete this study, is an example of how the qualitative assessment interview, initiated in the last trimester of the pregnancy, can detect areas of vulnerability early on. Her husband was difficult to reach. Once contact was established, he did not keep the arranged meeting. Esther received assistance from a "Visiting Mom" volunteer. After two visits, Esther canceled the service. She began going to her mother's home. Her case supports Thoits' (1982) premise that social support should be employed before the crisis occurs, as a preventative mechanism, rather than reacting to a problem after it has occurred. It also illustrates that it is more difficult to provide support if one is not receptive.

Three common themes emerged during the interviews. The first two helped to dispel the myth that newborn care and breastfeeding are instinctive behaviors. All of the couples readily expressed their lack of knowledge of parenting and newborn care. Further, those women planning to breastfeed

realized that this was an activity in which they would need instruction and on-going support. The third theme related to parental leave. In comparison to the national policies of other industrial countries, provisions afforded to these participants paled. Only two of the men were provided with paid parental leave, both receiving two weeks. The remainder utilized vacation and/or sick time. The women fared no better. Two women received some financial compensation as a designated maternity leave. Some, like the men, were forced to use vacation and/or sick leave. Other employed women received no maternity benefits. This information continues to demonstrate how far behind this country trails other industrial nations. More importantly, the lack of a national paid family leave conveys the low value placed on the work of parenting, and of equal significance, the lack of value placed on children, the future of our nation.

The qualitative interview rendered an accurate assessment with indicators that could be appropriately assigned to the Assessment Protocol. Since the participants were unaware of any ritualistic practices in the immediate post partum period that element in the interview could be eliminated. However, the absence of responses related to the practice of rituals represents a noticeable void in the support system, which substantiates the research of Stern and Kruckman (1983).

An unplanned pregnancy may contribute to the couple's overall stress level. However, as evidenced by the narratives, whether the pregnancy was planned or unplanned, couples expressed similar feelings of anxiety, ambivalence, and stress. An unplanned pregnancy appeared to have little impact on their need for post partum support and the ability to incorporate the baby into the family unit.

All of the couples appeared to have reasonable expectations of what life would be like once the baby arrived. They anticipated impending change in

their personal lives, in their relationship as a couple, and in their social lives. Many of the participants, more often the males, spoke of the increased responsibility they faced with the arrival of their baby. All, however, were clear that although preparation was helpful, bringing baby home was quite a different reality. Couples spoke of terror, frustration, exhaustion, lack of confidence, and being overwhelmed in the immediate post partum period.

Gathering a family history provided insight into the complex family relationship of each couple. The use of the genogram to obtain family information proved to be efficient and expedient. It provided a quick visual map identifying family members as potential sources of post partum support. Conversely, it highlighted the absence of resources, thus providing an opportunity to explore alternate options.

Listening to participant's memories of play was revealing. It contributed to a better understanding of an individual's capacity to compromise, problem solve and incorporate humor into a relationship. Greg is an example. His recollections of play revealed his difficulties with establishing and sustaining relationships.

Consistent with the research of Belsky (1984, 1994), Daniels and Weingarten (1980), Lewis (1988) and Vondra (1993), the most compelling indicators of a couple's ability to smoothly transition into the parenting role were ego development, and how the individual functioned in his/her dyadic relationship. These elements highlighted the strengths that the individuals brought to their relationship. Their responses illuminated their capacity to change their thinking, to accept another point of view, and to disagree in a constructive manner. Information gleaned from these three elements provided a window to understand more clearly what support a couple might require in the immediate and early post partum period. Gaining insight about an individual's

level of energy proved to be valuable, especially when evaluating how well an individual would function when deprived of sleep. Learning about recent life events was additionally helpful in developing a comprehensive post partum support plan.

The Assessment Protocol proved accurate in predicting necessary support. The follow-up interview one month after the birth of the baby helped to evaluate its effectiveness in identifying the degree of needed post partum support.

The Support Protocol appeared to assign an over abundance of formal support to the couples needing minimum support. The post partum time line indicates that the first and second week are the most critical, which concurs with the research of Crnic and Greenberg (1987) and Dorr (1981). This research suggests that home visits during this time provide the most effective support. The participants eloquently described the benefits of social support and highlighted the effects of misguided support. They illustrated how a comprehensive support network can assist a couple's transition into the parenting role. They revealed how one's attitude, or receptivity of support can influence its effectiveness.

All the couples agreed that they could not have predicted the level of support that they would need in the immediate and early post partum period. They felt unprepared for the overwhelming exhaustion. They had not anticipated and were unprepared for the amount of emotional and physical energy necessary to care for a new baby. Many of the couples, especially those who breastfed, were amazed at the amount of time that was spent, "just feeding the baby." Some spoke of the magnitude of laundry generated from just one baby. Those couples who received a home visit overwhelmingly agreed that it was helpful. The constantly reiterated phrase, "it was reassuring" was striking.

Many agreed that a visitation schedule from a professional, supplemented by phone calls, would have assisted them in the immediate post partum period especially the first two weeks post partum, which they identified as the most critical. According to some of their suggestions a more comprehensive support provision should be considered. It might be prudent, for instance, to include a variety of formal support providers, such as a Doula, a visiting nurse, a lactation specialist, or a homemaker. Those couples with a comprehensive social support network transitioned into the parenting role with greater ease. All of the couples agreed that, "Having a baby is a challenge. It's so much work!" They acknowledged that this experience has been a major life change. They described it as the biggest adjustment. "You don't have any time for anything else." One participant said, "You don't have time to do anything, even going to the bathroom or getting something to eat, especially, if you're alone."

What would have helped

I asked the participants to share their ideas both about what would have helped them prepare for the post partum experience and what would have been beneficial in helping them transition into the parenting role. In addition to the home visitation schedule (supplemented with phone calls) during the first and second week, other suggestions included a packet with support resources given to them in their last trimester. The women who had contacted breastfeeding resources before the birth found that to be the most helpful. Many stressed that they should have been more informed about the post partum period. Many cited the childbirth education classes as the forum for sharing that particular information. Some felt that the childbirth classes could have placed some emphasis on the psychological aspect of pregnancy and post partum. One childbirth class included the opportunity for couples to socialize. Those

who attended this class, lived in close proximity to one another which made it possible for one participant to organize a Mother's Group. She enlisted two couples from her childbirth class to join her post partum Mother's Group. This model could also be helpful for men interested in organizing a Father's Group.

Cowan and Coie (1978) followed a small sample of first-time parents from the last trimester of pregnancy to one year post partum. Some participants in their study revealed that they had never held a baby. As a result they asked the participants to bring their newborns to the group. Those participants encouraged the prenatal couples to hold the baby. In this study one woman who, like most of the participants, had no experience with babies, suggested that having an opportunity to hold a new born and "just be in the company of a newborn" to observe the mannerisms could have reduced some of the anxiety she experienced getting to know her new baby. This suggestion has merit, since so many of the couples were not clear about "what was normal." For instance, they were unfamiliar with the variety of sounds a new born makes, and the manner in which newborns breathe.

One father suggested that new parents should be given a card with the names and telephone numbers of the medical staff. Included on the card could be scheduled telephone times when the physician is available. Follow-up visits could be included on the card as well.

All the women who breastfed their babies felt they needed support. Their experience clearly dispels the myth that breastfeeding is an instinctive function. Those women who were supported had a successful breastfeeding experience. In contrast, those women who were not supported abandoned breastfeeding.

Implications for Clinical Practice

This study has already been useful in my clinical practice. I have shared

some of the suggestions with families that I have visited and with other clinicians.

Implications for Teaching and Training

There are implications, guided by the results of this study, for teaching childbirth educators what is most meaningful and helpful to pregnant couples. Instructors may consider rethinking the curriculum and format of their class. Time should be devoted to open discussion related to the couples' psychological experience as well as providing time for couples to socialize in order to develop a relationship and a potential support network. In addition, participants could benefit from a better understanding of some of their post partum needs in order to explore their options for support.

This study has clear implications for physicians, especially pediatricians who should understand the post partum recovery process. They need to be sensitized to the stress new parents experience as they transition into the parenting role. Pediatricians should learn ways that they can assist in that process.

The health care providers who specifically work with this population would benefit from the information gathered from this research study so they too can support new parents in their post partum adjustment phase. Taking the time to employ the Assessment Interview as a routine practice with pregnant clients can help detect those individuals, like Esther and Christine, who may require maximum support in the post partum period. Utilizing this protocol has the potential to reduce unnecessary medical expenses, anguish and human cost.

Implications for Health Insurance

Health insurance companies should consider using this Assessment Protocol as part of a cost benefit analysis. The most dramatic example from this

particular study was the case of the woman who developed a uterine infection that required re-hospitalization. It would be worth exploring how many of these cases occur each year. Having health insurance does not guarantee post partum support.

Recommendations for Further Study

Conducting a study with a larger and more culturally diverse sample could increase what has been ascertained from this small sample. If one were planned, it would be important to explore ritualistic practices. Conducting a comparative study between a sample receiving social support from a Doula with those not receiving specific social support could prove to be informative and enlightening which may further substantiate the need for universal post partum support.

Further Recommendations

Implications for Public Policy

I am confident that this study can serve as a catalyst for developing a policy for universal post partum support. This study which supports existing research has clearly demonstrated that a post partum support network helps to reduce anxiety and assists a couple in the process of transitioning into the parenting role. I suggest implementing the Assessment Protocol to determine the degree of necessary support in the post partum period for all first-time parents, rather than the existing arrangement ,which assumes that only a select group should receive support.

The importance of a national paid parental leave policy cannot be overstated. This study demonstrates the need and its benefits. Participants who had to return to work experienced additional stress to themselves and their partners. Those who were home were available to provide much needed

support.

The couples began their journey with very few guide posts to show the way. They can attest to the accuracy of the words of T.S. Eliot who wrote,

"And what you do not know is the only thing you know."

This study, without a doubt, illustrated the sense of accomplishment each couple achieved in undertaking one of the hardest jobs they'll ever encounter.

As healthcare professionals we must direct our energies to make that job easier.

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APPENDIX

1. Alpha-Fetal Protein Test (AFP)

The AFP (Alpha-Fetal Protein) is a test to specifically identify Down's Syndrome and Spina Bifida. The test is considered a non-risk procedure because it is procured by a blood sample from the expectant mother. The test results, however, are not reliable. Many false positives occur, which then requires further testing, such as an amniocentesis, to either verify or negate the positive finding of the AFP test.

2. Amniocentesis

Amniocentesis is an invasive procedure which involves inherent risks. In addition there is usually a lengthy time lapse between the procedure and receiving the results. Both of these factors can provoke additional stress for the couple.

3. Visiting Moms Program

This program is sponsored by the organization, Jewish Families and Children's Service. It provides support to mothers in need. The program is serviced by trained and supervised volunteers, who are mothers as well. Volunteers who assigned to a client visits at least once a week and can visit for up to one year, if needed. There is no fee for the client.

ID # _____

Date _____

Interview for First Time Parents

Section I

Pregnancy History, Pregnancy and Aspirations

I would like to begin with some questions about the pregnancy and your thoughts about your life with a baby.

1. Can you tell me a little about your pregnancy.

Is this your first pregnancy? ____ Yes ____ No

If **NO** Tell me about your other pregnancy(ies)

How has this pregnancy gone so far?

Is the timing of your pregnancy in keeping with your overall plans? __yes __no

If **NO** What would you have planned?

2. What do you think life will be like after the baby arrives?

What do you know about your baby so far?

Baby's sex ____boy ____girl

Baby's name _____

ID # _____

Date _____

Section II**Family History / Genogram**

Studies suggest that an individual's family plays a role in who one is and what one does. I would like to ask you some questions about your family, where you fit in and how you grew up in your family. I'd like to begin with a genogram.

3. Genogram

4. Do you or your family practice any particular celebrations / rituals around the birth of a baby? ____yes ____no

If **YES** Could you describe it(them)?

5. During one's growing up there are often memories of playing. Can you describe some of your memories of playing.

Did you play ____alone ____with a friend ____with a group of friends
____with your sibling(s)

Can you describe some of that playing

ID # _____

Date _____

What did your parents think or say about your play?

Did your parents ever play with you? ____yes ____no

Could you tell me more?

Was there a time in your growing up that you would say you have stopped playing ____yes ____no

Can you describe that for me

6. How would you describe yourself?

What are some of your strengths?

What about your weaknesses?

7. How would you describe your level of energy? ____High ____Medium ____Low

Are you someone that requires a lot of sleep? ____Yes ____No

How many hours? _____

What are you like if you don't get enough sleep?

Section III

Demographics

ID# _____

Expected Due Date _____

Hospital for Delivery _____

DOB-----

Number of Pregnancies-----

Length of time in this relationship-----

Education

High School Graduate-----

one year beyond high school-----

two years beyond high school-----

three years beyond high school-----

College Degree

Baccalaureate-----

Master-----

Doctorate-----

Other-----

Employed out of the home----Yes / No

If yes, please describe-----

-

Does your place of employment offer parental / maternity leave?-----Yes / No

Is the parental / maternity leave a paid leave? -----Yes / No

What is your Health Insurance?

What services do you expect your Health Insurance will provide after the birth?

Will you have anyone help / support you when you come home with your baby?Yes / No

Who do you anticipate will provide the help / support?

What kind of help / support do you expect? How long do anticipate you will need help / support?

ID # _____

Date _____

Prenatal**Anticipated Support**

Instructions: Please take a few minutes to review and choose the support choices you feel will best meet your needs once you return home from the hospital with your baby. You may check more than one of the choices.

Once I arrive home from the hospital with my baby and begin to adjust to the role of a new parent I anticipate I will benefit from:

Telephone Calls

-----**One** telephone call from a supportive professional

-----**Daily** telephone calls from a supportive professional for **one week**

-----Telephone calls **every other day** for **one week** from a supportive professional.

Telephone Calls and Visit Combination

-----**One home visit the first week** followed by **telephone calls every other day for one week** from a supportive professional.

-----**One home visit for the first two weeks** followed by a **telephone call in between visits**

-----**One home visit for the first three weeks** with **optional telephone calls**

Home Visits

- One** home visit from a supportive professional the **first week home** with the baby.
- One** home visit from a supportive professional for the **first two weeks home** with the baby **followed by a home visit every other week for two weeks.**

ID # _____

Date _____

- One** home visit from a supportive professional for the **first three weeks home followed by a home visit every other week for two weeks**
- Two** home visits from a supportive professional the **first week home** with the baby.
- Two** home visits from a supportive professional the **first week** followed by **One** visit for **the next two weeks**
- One** home visit from a supportive professional for the **first three weeks** home with the baby.
- One** home visit from a supportive professional for the **first four weeks** home with the baby.
- Weekly** home visits for the **first four weeks followed** by home visits **every other week** for the **next four weeks** from a supportive professional.
- None of the above
- Suggested support not included _____

INFORMED CONSENT

Title of the Research Study

Determining Degrees of Support in the Immediate and Early Post Partum Period

Principal Investigator

Marilyn Fraktman, Doctoral Student, Lesley College

Nature and Purpose of the study

The purpose of this study is to determine the degrees of support couples, who represent first time parents, may require in the immediate and early post partum period as they transition into the parenting role and begin to incorporate the baby into the family unit.

The nature of this study includes a separate interview with each of the individuals who represent the couple. This interview will be scheduled in the last trimester of the pregnancy. The interview will last approximately one hour per individual. In addition each person is asked to complete a prepared list of identifying information and a prepared list of questions related to anticipated needs following the birth of the baby.

One month after the birth of the baby the individuals will be asked to complete a prepared list related to what help / support would have been beneficial in the immediate and early post partum phase.

I have fully explained to _____ the nature and purpose of this research study and I have answered all questions to the best of my ability.

Principal Investigator _____

Date _____

I have been fully informed about the nature and purpose of this research study. I understand that participation in this study is voluntary and I am free to withdraw from this study at any time without reprisal. I understand that the information I give in this study is confidential.

I hereby agree to become a participant in this study. _____

Date _____

**PROTOCOL
FOR
DETERMINING
DEGREES OF SUPPORT**

ID# _____
Date _____

Code 1 Pregnancy History

- | | | |
|--------------------------------------|-------|----|
| a. Fertility problems | _____ | |
| b. perception of long time trying | _____ | |
| c. miscarriage | _____ | |
| d. abortion | _____ | |
| e. amniocentesis | _____ | |
| f. ambivalent pregnancy | _____ | |
| g. unplanned pregnancy | _____ | |
| h. unrealistic expectations- | _____ | |
| no sense of infant needs and demands | | |
| i. first grandchild in the family | _____ | |
| j. desire for certain sex baby | _____ | 10 |

Code II Family History

- | | | |
|--|-------|----|
| a. Alcoholism | _____ | |
| b. Mental Illness | _____ | |
| 1. Depression | _____ | |
| 2. Suicidal Ideation | _____ | |
| 3. Suicide attempt(s) | _____ | |
| c. Family Abuse / Violence | _____ | |
| d. Divorce | _____ | |
| e. Death of a Parent | _____ | |
| f. Death of a Sibling | _____ | |
| g. Chronic Illness | _____ | |
| h. Lack of Parental Nurturance | _____ | |
| i. Lack of Family support | _____ | |
| 1. Physical Distance | _____ | |
| 2. Emotional Distance | _____ | |
| 3. Conflicted Relationship | _____ | |
| 4. Fused Relationship | _____ | |
| 5. Tension re: generational practices | _____ | |
| with in-laws | _____ | |
| j. Poor Boundaries | _____ | |
| k. Family Secrets | _____ | |
| l. No Previous Experience with Infants | _____ | 20 |

Code III Family / Cultural Rituals

- | | | |
|---|-------|---|
| a. Lack of ritual practices | _____ | |
| b. Tension within family re: cultural practices | _____ | 2 |

Code IV Play History

- | | | |
|--|-------|--------|
| a. Lack of Play Experience | _____ | |
| b. Parents did not support Play Activity | _____ | |
| c. Solitary Play only | _____ | |
| d. No Team Play- | _____ | 4 (36) |

ID#_____

Date_____

Mental Status: Appearance + - Speech + - Emotions + - Thought Process + -

Thought content + - Sensory Perceptions + - Mental Capacity + -

Attitude Toward Interviewer + -

Brief Mental Status Description

Code V Ego Development

- | | | |
|---|-------|---|
| a. Dependent- | _____ | |
| b. Excessively Independent | _____ | |
| c. Poor Self-Esteem (<i>worthiness</i>) | _____ | |
| d. Poor Sense of One's Own Needs | _____ | |
| e. Lack of Friends (Best Friend) | _____ | |
| f. Controlling- | _____ | |
| g. Non adaptable to change | _____ | |
| h. Perfectionist- | _____ | 8 |

Code VI Level of Energy

- | | | |
|---------------------------------|-------|---|
| a. Needs Many Hours of Sleep | _____ | |
| b. Difficulty Resting / Napping | _____ | |
| c. Workaholic | _____ | |
| d. Needs schedule | _____ | |
| e. No Hobbies / Interests- | _____ | |
| f. Neatnick | _____ | 6 |

Code VII Nurturing

- | | | |
|--|-------|---|
| a. Inability to be Nurtured by Partner (<i>worthiness</i>) | _____ | |
| b. Inability to Nurture Partner | _____ | |
| c. Inability of Partner to be Nurtured | _____ | |
| d. Unable to Share vulnerabilities | _____ | 4 |

Code VIII Shared Responsibilities

- | | | |
|--------------------------------------|-------|---|
| a. Role Specific tasks | _____ | |
| b. Partner Makes the Major Decisions | _____ | 2 |

Code IX External Stresses

- | | | |
|---------------------------------|-------|--------|
| a. Financial | _____ | |
| b. Employment related | _____ | |
| 1. unpaid parental leave | | |
| 2. decision to return to work | | |
| c. Housing / Space | _____ | 4 (24) |
| d. Health Insurance constraints | _____ | |

T= 60

Tension points _____

ID# _____

Date _____

Individual Total _____

Combined Total _____

Support Protocol

Minimum Support-----1-15 indicators

One Home visit week one and two, followed by two home visits every two weeks= **5 wks**

Moderate Support-----16-30 indicators

One Home visit week one, two, and three, followed by two home visits every two weeks= **7 wks**

Maximum Support-----31-60 indicators

One Home visit week one, two, three, and four, followed by four home visits every two weeks=**12 wks.**

Optional phone calls will be negotiated



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